LOCALIS

LOCAL PRACTICE

Long-term sustainability through place-based health

By Zayn Qureshi
With Dr Geoffrey Boxer and Linda Boxer

About Localis

Who we are

We are a leading, independent think tank that was established in 2001. Our work promotes neo-localist ideas through research, events and commentary, covering a range of local and national domestic policy issues.

Neo-localism

Our research and policy programme is guided by the concept of neo-localism. Neo-localism is about giving places and people more control over the effects of globalisation. It is positive about promoting economic prosperity, but also enhancing other aspects of people's lives such as family and culture. It is not anti-globalisation, but wants to bend the mainstream of social and economic policy so that place is put at the centre of political thinking.

In particular our work is focused on four areas:

- **Reshaping our economy.** How places can take control of their economies and drive local growth.
- **Culture, tradition and beauty**. Crafting policy to help our heritage, physical environment and cultural life continue to enrich our lives.
- **Reforming public services.** Ideas to help save the public services and institutions upon which many in society depend.
- **Improving family life.** Fresh thinking to ensure the UK remains one of the most family-friendly places in the world.

What we do

We publish research throughout the year, from extensive reports to shorter pamphlets, on a diverse range of policy areas. We run a broad events programme, including roundtable discussions, panel events and an extensive party conference programme. We also run a membership network of local authorities and corporate fellows.

Contents

Acknowledgements

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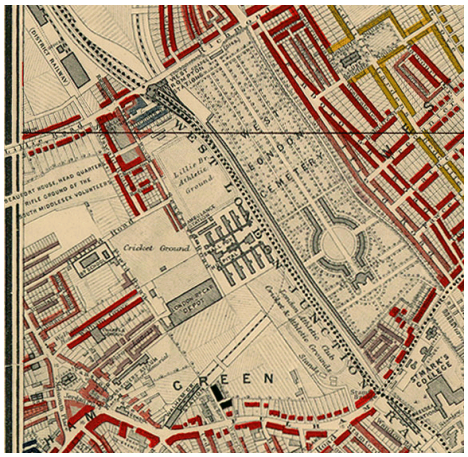
This report was also shaped by the contributions of experts in public health, particular thanks are owed to Jim McManus, Michael Wood, David Waller, Francesca Markland, Hannah Brayford and Dick Sorabji. While these individuals contributed to shaping the approach of this research, they may not agree with all of the conclusions reached. Finally, I would like to acknowledge the immense support of colleagues at Localis, particularly Joe Fyans and Jonathan Werran. Any errors or omissions remain my own.

Zayn Qureshi

This report is dedicated to the memory of Michael Tavares, who served Localis as a researcher of great zeal and distinction in 2018 and died of a young sudden cardiac arrest in April 2019. Life is the most precious of all treasures.

Executive Summary



When we think of mapping health onto place, the pioneering charts of Charles Booth, which sought to specify, with street-level accuracy, the actual working and living conditions of London's poor in the late 19th century, should come foremost to mind. As a piece of social cartography it can't be bettered. Poring through each chartered street, each colour-coded mark of sorrow, each mark of woe, the historical record of neighbourhood streets and alleys that encompassed individual lives and their wider sphere of community is laid out in a compelling visual totality.

Today with our incomparably vaster public and private knowledge infrastructure – whether NHS Digital's assets or Acorn consumer classification, and myriad data points on facets of a person's life far beyond anything any of Booth's Toynbee Hall researchers, armed with simple pen and pad, could have dreamt of, we should have the issue of place-based health licked.

Instead, and although its principles are now well-established and practiced, the full promise of a total place approach to area budgeting and comprehensive public service reformation in localities has faded, like one of Booth's maps. This is a pitiably missed opportunity. The Victorian era foundations on which today's local government structure was founded were struck in the series of parliamentary acts giving place a role and responsibility for public health and sanitation.

If the National Health Service remains, in Lord Lawson's memorable phrase, the closest thing the English people now have to a national religion, it's high time the general public started paying homage to the god of little things, the smaller deities which are public health and prevention.

But like all great religions, rationality must yield to faith and devotion - which is measured in what is given as tribute and the collection plate. This largesse hasn't always been the case. In 1953 the Treasury appointed the Guillebaud committee to find ways of constraining health spending. They reported two years later in 1955 that health spending was already naturally falling as a share of GDP with hospital building a fraction of the interwar rate.

At a time when ministers and officials are straining all means necessary to funnel billions of pounds from the health service's 70th anniversary budget boost into shovel-ready NHS schemes, there is a moral case for making population health and place investment count for the fullest amount possible. There is a case for putting place prosperity and local accountability to the forefront of a renewed drive for a health ecosystem that will be more than strong enough to meet the known challenges of demography, technology and the workplace revolution. Spending through the public health grant is up to four times as cost effective as NHS spending.

Local Practice is a case for place that is centred not around the need for

power transfer, but a localist case to liberate resources, assets and latent potential that exist within every community. It is a call to rationally manage limited resources and deploy data and new technology for the best results. It is a simple prescription to integrate agents of health and guardians of place at an appropriate level for the sake of delivering human-centred care to local populations through all stages of life.

Preventative care and the role of local services

Local government and public health

There is a symbiotic unity between our life and our environment. Inhabitants from the least deprived areas of England on average live for twenty years longer than those in the most deprived[1]. The health of a community is therefore inseparable from place and prosperity. Furthermore, the prosperity of place aggregates up to the benefit of the national economy. A well-balanced health and care system, one that allows local authorities to fulfil a statutory responsibility to public health, will be vital in tackling the Industrial Strategy's Grand Challenge of the ageing society. The case for place also extends to the health of our public finances, particularly those pertaining to the health service. It is in everyone's interest to foster conditions encouraging people to be healthier and more independent for longer and shift away from a treatment mindset. This chain of logic illuminates the reasoning for the deep-rooted historical public health duty assumed by local authorities since the 19th century.

Given the renewed focus on prevention, it is only natural that local authorities be leaders in the fight against public health challenges and how they manifest in communities. The last six years have shown us that tackling the myriad challenges facing our nation's health requires a holistic, collaborative and integrated approach. The Health and Social Care Act 2012 bolstered responsibilities and created the role of the Public Health Director in each upper tier authority. These directors play a key role in coordinating the council's approach to clinical commissioning, identifying needs assessments, and leading on local health protection specific to the community's needs. Despite this role, recently formalised but long-standing in practice, public health has not been spared the nine years of austerity which local government has borne the brunt of. It is estimated that between 2014/15 and 2019/20 the public health grant will have experienced a £700 million cut in real terms[2].

At the time of writing, the long-awaited Spending Review has not been timetabled. Instead we will see a one-year review, most likely along the prevailing fiscal trajectory. This means long-term funding for the public health grant is yet to be outlined, leaving local authorities unable to make forward budgetary decisions. If the government is serious about fixing the health and social care crisis, and shift efforts to prevention, cuts in public health funding need to be reversed immediately. Preventative care must be ring-fenced as a budget and considered alongside issues like schooling for disadvantaged children and care for the vulnerable elderly as a dynamic demographic pressure requiring special consideration.

Complex systems and preventative care

The need to go beyond linear clinical interventions has been recognised in academia through a complex systems model of public health. The complex systems approach recognises public health challenges as being multicausal in nature and doubts the effectiveness of measures designed around single interventions. While interventions on this scale might have minimal impact on the individual level, when aggregated on the population level, they will drive

1 Public Health Matters (2017) – Understanding health inequalities in England

2 Terrence Higgins Trust - Cuts to public health are cuts to the NHS: The need for continued investment in public health and prevention services

a much larger change. Taking this approach, interventions become a matter of the depth and reach of their impact on the overall population in question. Hertfordshire County Council was an early adopter in analysing health and social problems within the county using complex systems, taking a new way to decision-making rooted partly in scientific method and partly in pragmatism.[3] For example, tackling issues confronting the LGBTQ community requires addressing interventions on the individual and community level. This would involve interventions aimed at strengthening resilience on one hand, while implementing wider interventions that tackle stigma and build services which genuinely understand the community's concerns[4].

The Health, Exercise, Nutrition for the Really Young (HENRY) programme in Leeds has been a major success story in tackling childhood obesity through coordinated efforts of local services focused on delivering preventative measures. The foundational belief of the programme aligns with a complex systems approach, whereby simply providing isolated interventions on one level of the system is not enough. Childhood obesity, with all the challenges and solutions associated with it, needs to be viewed holistically. This is especially true for parents who face multiple challenges raising children in socioeconomic deprivation[5]. Grounded in its holistic approach, the programme entails interventions on all levels, centred around the child in its home and community environment, as well as the emotional wellbeing of the family. In 2019, Leeds drew national coverage[6] for being the first city in the UK to report decreased childhood obesity. Before this, Amsterdam had been the only city to report such a cut. The success in Leeds was only possible through a collaborative effort between the council's public health and children's services teams working together.

The Prevention Premium

In increasingly lean times, it is asking a lot of public health departments, which are already suffering from severely reduced grants, to engage in system-wide analysis when merely 'keeping the lights on' is becoming a realistic area of concern.

For this reason, we recommend that – in addition to the public health grant – local authorities with a public health duty be provided with a Prevention Premium, modelled after the Pupil Premium grant for school funding, to help support the transition to public health delivery interlinked across all council functions and wider civil society actors and institutions. The premium would be calculated based on demographic factors, reflecting the various different areas where deep, public health interventions, can be most effective. For illustrative purposes, we have selected some factors below to model where demand for preventative care interventions might be the highest in England. It is important to note that the indicators combined in our mapping do not form an exhaustive list and minsters and officials might well want to pick factors with a different emphasis in mind. For example, incidents of violent crime are not included in our mapping but may be considered to be a public health demand factor.

3 Localis Interview

4 Localis Interview

5 British Journal of Obesity (2015) - HENRY

6 The Guardian (2019) – Leeds becomes first UK city to lower its childhood obesity rate

Stage	Indicator	Definition	Source
Wider determinants	Unemployment rate	Percentage of the working age population who are claiming Jobseeker's Allowance plus those who claim Universal Credit and are required to seek work and be available for work.	Department for Work and Pensions
	NEETs	Percentage of 16-17 year olds not in education, employment or training or whose activity is not known.	Department for Education
	Children in low-income families	Percentage of children under 16 living in families in receipt of out of work benefits or tax credits where their reported income is less than 60% median income	HM Revenue and Customs
	Over-65s	Percentage of the population over the age of 65	ONS mid-year population estimates
Lifestyle factors	Smoking prevalence	Prevalence of self-reported smokers	Annual Population Survey
	Childhood obesity	Prevalence of obesity (including severe obesity) of children in year 6	NHS Digital, National Child Measurement Programme
	Physical inactivity in adults	The number of respondents to the Active Lives Survey doing less than 30 minutes activity per weeks, as a percentage of total respondents aged over 19	Public Health England
	Substance abuse young people	Directly standardised rate of hospital admission for substance misuse, per 100,000 population aged 15-24	Local Authority Child Health Profiles/ Public Health England

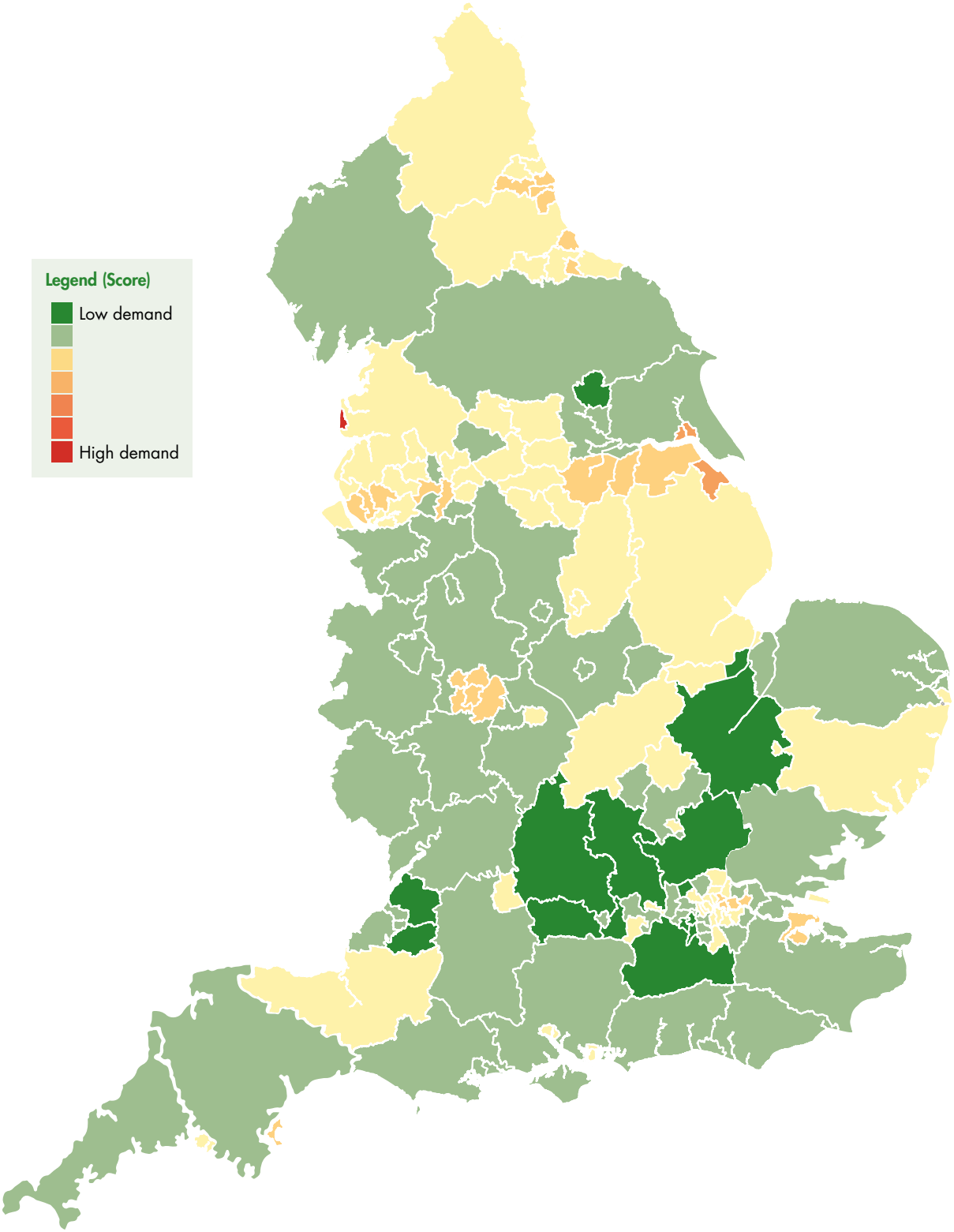
The role of place in the NHS

Consumer-led healthcare

The other side to the coin of the local authority role in public health is the self-responsibility of individuals to look after their own health. Government needs to become more serious about developing and encouraging consumer-led healthcare, focusing on methods for disease prevention and reducing demand by incentivising individuals to look after their own health better. The funding of programmes to promote and encourage consumer-led healthcare must critically consider the ongoing accruing value of such enterprises.

Currently, the major challenges are to:

Total preventative care demand score



- clearly demonstrate that capital investment leads to a significant reduction in future healthcare costs;
- identify funding streams that will support projects and posts;
- make the clear financial case for funding additional health economists capable of evaluating how demand-reduction affects NHS budgets.

The NHS will enjoy direct financial benefits from cost -reductions across a range of services, including in-patient episodes, pharmacy budgets, GP and outpatient appointments, district nurse services and service provision (pathology, physiotherapy, imaging, dietetics). Companies will reap the additional benefits of improving their productivity by developing a more stable and healthier workforce. Some charitable organisations operating within the healthcare sector have to divert much of their funding and resources to support individuals with chronic conditions developed as a result of poor lifestyle choices. We believe that there is a growing expectation that the consumable spending of charities should be allocated to the most deserving causes and that a drive to encourage self-managed healthcare will allow this.

Locally-delivered healthcare

Whilst the NHS gains huge strength from its networking capability, its facilities, and a standardised approach to working, one of the drawbacks of being a national health service is that for the most part the same standard and quality of service is expected to be delivered across all conditions, for all demographics and with all infrastructures. Currently, CCGs are tasked with commissioning and ensuring the delivery of healthcare locally. But is that really local? Since their initial establishment as 213 groups in 2013, over the past five years a process of rationalisation and mergers have occurred, such that by the end of this year there may be only 174 CCGs. Some of these, such as NHS Birmingham and Solihull CCG serve as many as 1.2 million patients. The greater the population that any CCG serves the less focused they can be on the needs of individual groups. Those needs can vary dramatically for patient groups with different ethnicities, religious faiths, socio-economic backgrounds as well as the unique rhythms and pressures of domestic and working lives. In addition, the workload and demand for services within any community can at times escalate unpredictably and increase the immediate pressure on the system.

It would be nice to think that the delivery of healthcare can always be a simple and smooth process, one by which people's normal condition can be maintained or defects rectified at times so they can get back on the road to health. The reality is very different and perhaps we should start to think of how we react to symptoms of serious disease more like we do for accident and emergency or epidemics. Because, as with natural disasters, damage to infrastructure and inevitably sometimes loss of life, are the knock-on effects for patients and health services that have to be addressed. We need to be able to divert resources quickly to address the problems of individuals, groups or communities in a way that might be appropriate in one area and not in another.

The role of NHS patient data in place-based health

The value of access to and use of data has long been demonstrated in the field of epidemiology, most notably for improving public health. Major advances have been made in infection control, including prevention of tuberculosis, smallpox and polio, and more recently human papilloma virus (HPV). Despite this major role that the NHS has played, since its inception it has failed dramatically to understand the full value of all the data that it generates and holds, and the information and knowledge that this yields. Currently there is no national solution

for locating and sharing electronic patient records[7], impeding the delivery of integrated care on all levels. Going forward, it is important to learn from the mistakes of the National Programme for IT (NPfIT). This was an earlier attempt at creating an IT infrastructure that connected general practitioners to hospitals across the country, and created electronic patient records. The biggest obstacle to this was the overreach of a 'centralised authority making top down decisions' for local organisations[8]. Key to the success of the above initiatives is a localist, grounded approach, and end user engagement.

The sharing of NHS patient data will continue to be viewed with more than a little suspicion by the general public with regards to its security and anonymity – especially once stored in data warehouses that are external to the NHS. If patient data is to be used across silos to improve care, it is of paramount importance to deal with the fears and trust of the general public, many of whom believe that allowing their medical information to be accessed means that it can be used nefariously. Government, NHS and local officials will need to work more closely with computer science departments at universities and other academic centres, as well as collaborate with the computer industry to develop systems for the storing, mining and analysis of such huge and sensitive databases.

Staffing the NHS and social care

Compounding the myriad issues facing the health economy discussed throughout this report is the worrying level of workforce vacancies it now routinely faces. Current estimates show that there are over 100,000 staff vacancies in the NHS, with little chance of training enough GPs and nurses to solve the current crisis[9]. At the moment, there are over 40,000 nursing posts vacant, which is one in nine posts[10]. This also includes a decline in the number of community health and mental health nurses. With social care, there are currently 1.5 million people working in the sector, but as the population increases and lives longer, in 15 years there will be a need for an extra one million carers[11]. This is before taking into consideration the similar levels of staff shortages in the NHS.

Heath and social care has always relied, to varying degrees, on immigration to fill staff shortages. Viewing this alongside the demographic changes occurring as a result of internal migration within the UK shows us how certain parts of the country rely on immigration more than others. Migrants make a unique contribution to the sector and are doing more than simply substituting for British labour; they are filling skills gaps the British working age population seem unwilling to plug. In all six English regions below the River Trent, non-domestic workers account for at least one in ten adult social care professionals. In London and the South East, workers from abroad provide 40 and 23 percent of social care staff respectively. Already, ongoing Brexit uncertainty has had an impact on the health and social care sector as more potential care workers are deterred from entering the UK jobs market.[12] Migration policy should not intensify the problem by placing obstacles in the way of recruiting the skills and labour the sector needs.

This involves a necessary boost of investment into the social care budget, which would allow for raising wages, and creating new opportunities and prospects for social workers.

7 NHS Digital (2018) – The National Record Locator Services

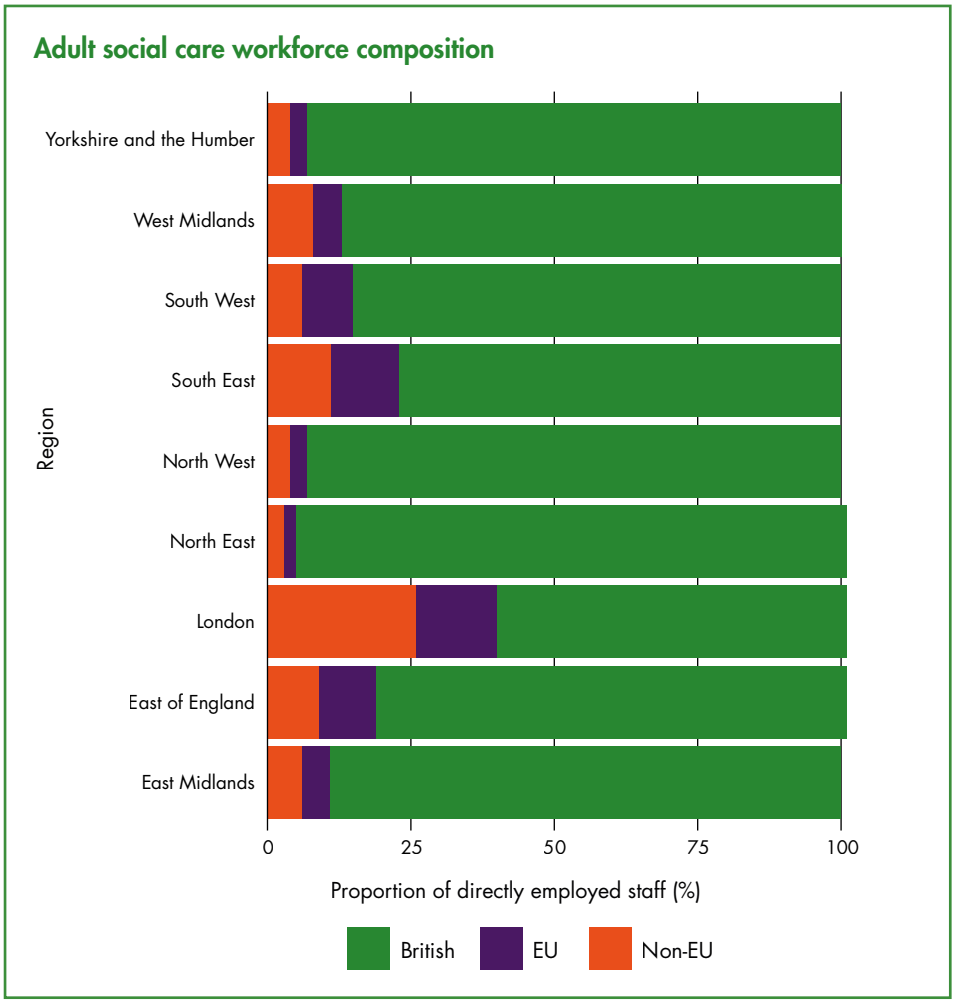
8 Justinia T (2017) – The UK's National Programme for IT: Why was it Dismantled?

9 BBC News (2019) – NHS has 'no chance of training enough staff'

10 The Health Foundation (2019) – A critical moment: NHS staffing trends, retention and attrition

11 Timewise – Social care crisis: How to keep the carers we have and attract a million new ones

12 Localis Interview



Source: SkillsForCare Workforce Intelligence.

A comprehensive immigration system that puts place-based needs first is essential post-Brexit. We propose a deal whereby visa quotas per sector are devolved to local government as they are best suited to know the needs for growth in their area. Currently, individual NHS trusts are involved with extensively recruiting from abroad, and the government continues to ease visa restrictions to facilitate this[13]. The immigration element of health and social care staffing dovetails with the training of domestic workers when considered as an issue of decentralisation. In systems where local government has greater power over its destiny, approaches to immigration vary according to economic circumstance, demographics and institutional need to name just a few factors[14]. More local control over how visas for health professionals are distributed is a natural conclusion of this research.

13 ITV (2018) – NHS to recruit thousands more foreign doctors and nurses as visa cap lifted

14 Graeme Boushey and Adam Luedtke (2011) - Immigrants across the U.S. Federal Laboratory: Explaining State-Level Innovation in Immigration Policy

Recommendations

1. **We reiterate our call for local authorities to be given a coherent and comprehensive finance settlement that is fit for purpose.** One that is set on longer cycles of ten years, which would facilitate long term planning of the prevention agenda.
2. **In addition to the public health grant, upper tier local authorities should be provided with a Prevention Premium, modelled after the Pupil Premium grant for school funding, to help support the transition to public health delivery interlinked across all council functions and wider civil society actors and institutions.** The premium would be calculated based on demographic factors, reflecting two pinch points for public health. On the one hand, the rate at which the population is ageing and on the other the prevalence of child poverty.
3. **The new government should work toward releasing the Social Care Funding Green Paper at the earliest convenience, the paper should contain guidance on the joining-up of services to create holistic public health strategies as a form of preventative care.**
4. **The beneficial role Local Economic Anchors can play in tackling emerging public health challenges should be recognised by giving them a seat at the table on Health and Wellbeing Boards**. This would lead to further collaboration between all local stakeholders including the local health and social care sector, local authorities and business.
5. **Integrated Care Systems should be funded to employ health economists,** to evaluate public health initiatives within a place and their effect on local NHS demand.
6. **Roles should be created within Integrated Care Systems for marketing specialists,** to work with local authorities within the ICS area to develop links between the NHS, the local community and the commercial healthcare and fitness sectors.
7. **Constituent local authorities should be given a formalised role to act as conveners for Integrated Care Systems to actively engage with local educational institutions,** to ensure a holistic, joined-up health education system, sensitive to local context, is in place.
8. **CCG mergers should be halted and rolled back,** with the aim of achieving parity with local government to ensure the legitimacy of locally-delivered healthcare.
9. **Government, the NHS and local authorities must commit to greater collaborative working. Central to this, these partners must also sensitively and securely unlock greater potential from locally-derived patient data 'the jewel in the health service crown'.** This will mean funding to build robust systems for the effective storing, mining and analysis of larger databases including clinical and public health outcomes at appropriate sub-regional level. From this point forward, joint funding arrangements involving NHS England should be put in place, with the goal of analysing the success of health interventions across local public services.

10. **In line with existing reforms to public property assets, efforts should be made by managers of the NHS estate to co-locate different healthcare professionals from across the health service** – e.g. GPs, nurses, pharmacists – in modern working environments within the community that support best patient care.

11. **A joint nursing role that combines health and social care responsibilities should be created**. This would accelerate steps toward delivering integrated care, give nurses a practical understanding of what this means, and offer concrete career prospects. For example, by employing individuals on a rotational basis whereby they work part time in the community, and part time in the acute setting, one would develop a range of skill sets, which would allow people more scope and opportunity regarding their career prospects.

12. **A comprehensive immigration system that puts place-based needs first is essential post-Brexit. We propose a deal whereby visa quotas per sector are devolved to local government as they are best suited to know the needs for growth in their area.** Local authorities in partnership with local NHS trusts are in a better position to identify their and recruit for themselves. Even outside of healthcare, local authorities can identify key sectors where immigration is needed and can fill gaps whilst creating incentives for people to take opportunities to train and work in their areas.

13. **Efforts should be doubled to reverse the fall in numbers of nurses, GPs, and other health and social care professionals through a focus on increased homebased training**. A start should be reversing the abolition of bursaries for nursing students. More institutions and places to study should be made available, with clear incentives laid out for training in specialities where there are current shortages. This should involve having clearly laid out opportunities for an upward career trajectory to boost morale.

14. **Efforts should also be made to attract more young British people to work in social care, especially in areas which have experienced a brain drain and thus have a higher median age**. This involves a necessary boost of investment into the social care budget, which would allow for raising wages, and creating new opportunities and prospects for social workers.

1. Preventative Care and the Role of Local Services

This chapter looks at the increased focus on prevention within public health and what local service providers are doing to better integrate the delivery of care. Recent years have brought heightened attention to the changing demographics of the UK, particularly those associated with our ageing population. Much of the change boils down to an uptick in projected population to 73 million by 2041 and an accompanying increase in life expectancy leading to a gradually increasing median age[15]. Concomitant challenges facing the healthcare sector relate to how we keep the nation healthy in a sustainable manner, given the demographic pressure. Recognising the impact of wider determinants of health is key to meeting this challenge. Scholars and practitioners of public health alike are beginning to use a model of 'complex systems'[16] to help conceptualise the task at hand. Integrated delivery of care, management of environmental factors and social provision in communities is needed to ease pressure off the health service and care system.

1.1 The role of place in health, society and economy

The surroundings in which we grow up are an important determinant of our health. There is a symbiotic unity between our life and our environment. Those living in the least deprived areas of England on average live for twenty years longer than those in the most deprived[17]. Access to education, transportation, housing, food, and good work are a few of the factors which need to be considered when judging how demographic changes vary across different communities in England. They inform the everyday life decisions of an individual, which reify health outcomes. The health of a community is, therefore, inseparable from place and prosperity. This chain of logic illuminates the reasoning for the deep-rooted historical public health duty assumed by local authorities since the 19th century.

Of course, the prosperity of place aggregates up to the benefit of the national economy. A well-balanced health and care system, one that allows local authorities to fulfil a statutory responsibility to public health will be, therefore, vital in tackling the Industrial Strategy's Grand Challenge of the ageing society. Its mission is to 'ensure that people can enjoy at least five extra healthy, independent years of life by 2035, while narrowing the gap between the experience of the richest and poorest[18]. This will be impossible if integration, and cooperation, between the different actors of the health and care sector is not achieved. Realising this mission necessarily entails having a place-based system that concentrates on the local determinants of our health and maximises prevention.

The case for place also extends to the health of our public finances, particularly those pertaining to the health service. The link between local government and the NHS becomes apparent when considering how well-run public health programmes

15 ONS (2018) – Overview of the UK population: November 2018

16 Rutter, H. et al. (2017) The need for a complex systems model of evidence for public health

17 Public Health Matters (2017) – Understanding health inequalities in England

18 Department for Business, Energy & Industrial Strategies (2019) – The Grand Challenges

keep pressure off hospitals. The need for this will only increase as our country gets older. It is in everyone's interest to foster conditions encouraging people to be healthier and more independent for longer and shift away from a treatment mindset. The recent promise by former prime minister Theresa May of an additional £20 billion on the annual health budget by 2023 has been warmly welcomed by Sir Simon Stevens, chief executive of NHS England. And current prime minister Boris Johnson is keen to release this money to twenty priority areas. However, tackling the associated problems of an ageing society requires wider attention outside the acute setting. We need to stop viewing the NHS as having sole responsibility for our health and look at what we can do in our communities first and foremost. Well-funded local authority health services are crucial in safeguarding the NHS and adult social care for the future. The benefits of this are self-evident, especially considering how 'pound-for-pound' we get four times as much health functions in local government than we do from NHS spending'[19].

1.2 Local authorities and public health

The Health and Social Care Act 2012 gave public health responsibilities to local government in England. The idea behind this being 'local leadership for health will be at the heart of the new public health system'[20]. This would allow authorities to take charge of designing public health measures fit for their own circumstances and needs. Localism and democratic accountability were guiding principles in the decision to hand public health to the local state. Given the renewed focus on prevention, it is only natural that local authorities be leaders in the fight against public health challenges and how they manifest in communities. The last six years have shown us that tackling the myriad challenges facing our nation's health requires a holistic, collaborative and integrated approach.

Local authorities have always had responsibility over public health, an example being the Local Government Boards. These were created by an Act of Parliament in 1871 and took over responsibility for local environmental health services and vaccine administration[21]. However, the 2012 act bolstered responsibilities and created the role of the Public Health Director in each upper tier authority. These directors play a key role in coordinating the council's approach to clinical commissioning, identifying needs assessments, and leading on local health protection specific to the community's needs. The main domains they are responsible for are public health, health improvement, and health protection. The new functions given to the local authorities are to increase health standards, to protect local populations against threats to their health and liaise with NHS bodies on the local level to discuss emerging issues.

Despite this role, recently formalised but long-standing in practice, public health has not been spared the nine years of austerity which local government has borne the brunt of. Prevention has been recognized by the Department of Health and Social Care in their policy paper[22] published in 2018. The previous prime minister also acknowledged the power of prevention in stopping the symptoms of ill health before they develop[23]. Despite this explicit recognition by central government, the public health grant has seen yearly cuts. It is estimated that between 2014/15 and 2019/20 the grant will experience a £700 million cut in real terms[24]. This level of budget reductions would be deemed politically unacceptable were it enacted against the protected NHS and not local government.

Continual cuts are having a damaging effect on the ability of local authorities

19 The Kings Fund (2019) – Public health spending: where prevention rhetoric meets reality

20 Department of Health – The new public health role of local authorities

21 The National Archives – Public health and epidemics in the 19th and 20th centuries

22 Department of Health & Social Care (2018) – Prevention is better than cure: our vision to help you live well for longer

23 Prime Minister's Office (2018) – PM speech on the NHS: 18 June 2018

24 Terrence Higgins Trust - Cuts to public health are cuts to the NHS: The need for continued investment in public health and prevention services

to fulfil their public health responsibilities. Despite this, they have had successful outcomes, especially in areas like sexual health[25]. At the time of writing, the long-awaited Spending Review has not been timetabled. Instead, we will see a one-year review, most likely along the prevailing fiscal trajectory. This means long-term funding for the public health grant is yet to be outlined, leaving local authorities unable to make forward budgetary decisions. If the government is serious about fixing the health and social care crisis, and shift efforts to prevention, cuts in public health funding need to be reversed immediately. If not, we will continue to be stuck in an acute treatment approach to health. Preventative care must be ring-fenced as a budget and considered alongside issues like schooling for disadvantaged children and care for the vulnerable elderly as a dynamic demographic pressure requiring special consideration.

1.3 Joining the dots

Public health initiatives have begun to focus on prevention, which can be divided into three categories; primary, secondary and tertiary[26]. The first aims to reduce health risks to a population through universal measures or targeted intervention. The second focuses on early stage intervention before disease fully develops, and the third looks to help people soften the impact and manage their ongoing long-term illness and live comfortable lives. Support in living with illness is possible through social care provided by local authorities. Social care encompasses a number of services from childcare to end of life and disability support and is the responsibility of local government. As Localis has argued before, the local state can improve quality and efficiency of care services in cases where governance is properly aligned, and local authorities are used as an important source of democratic accountability[27]. Further strengthening the capacity of the local state will require a sense of willingness and confidence on the part of central government for local authorities to resource themselves to a greater extent through fiscal devolution.

It is important to see public health interrelated with prevention and social care. This allows for the recognition that it is a multicausal phenomenon, requiring holistic solutions. Public health initiatives, for a while now, have been looking at how individual factors interact with wider environmental ones in affecting our health. In seeking to maintain a healthy and fit population, there has recently been a strengthened drive to focus on and manage these wider determinants, rather than only on the delivery of healthcare. Socio-economic inequality, education, and environmental change - to name a few - are all important factors for consideration.

Population health recognises the need to move away from treatment and go beyond the NHS frontline in seeking solutions to tackle health inequalities. The Kings Fund argues that a framework for population health needs to focus on the overall health outcomes of the entire population, instead of how well the systems that deliver the services are performing. This framework for action identifies four pillars that together form the basis of a population health system[28]. The first pillar focuses on wider determinants of health such as education, income, housing and transport amongst others. The second looks at health behaviours and lifestyles including alcohol and tobacco consumption, diet and levels of exercise. The third pillar focuses on place and communities. The fourth is on the continued development of integrated health and care systems, which reflect the needs of patients with long-term conditions such as Alzheimer's disease.

For the population health system to work effectively, all four pillars must be taken as an interconnected whole and work equally. There need to be concerted efforts on the local level to deliver long-lasting improvements to population health.

25 BBC (2019) – Public Health 'improving under councils despite cuts'

26 Local Government Association – Prevention

27 Localis (2019) – Hitting Reset

28 The Kings Fund (2018) – A vision for population health: Towards a healthier future

Levers of local authority influence

	Statutory duties		Influence
	Statutory powers		Assets
	Discretionary powers		Partnership

Six levels of system action

1	**Social** e.g. changing behaviour
2	**Biological** e.g. immunisations, vaccinations, treatments
3	**Environmental** e.g. changing the public realm
4	**Behavioural** Individual choices
5	**Legislative** Bans, taxes
6	**Structural** Policy changes within institutions

Working with a systems approach

Conceptualise

The world you're trying to influence.

Consider

The levels of action.

Consider

The type of evidence you'll need.

Refine and Adapt

To build a 'multi-layered model'.

Source: Jim McManus, Hertfordshire County Council

Strong political and local systems leadership is essential in making sure that, on a national level, improving population health remains a priority. And at local level, that the placed-based structures are fit for the purpose of meeting an area's unique future challenges. With the latter, this means each constituent part of the local healthcare system and their local government counterparts all understanding their roles and working together.

1.4 Public health and complex systems

The need to go beyond linear clinical interventions has been recognised in academia through a complex systems model of public health. This approach views 'poor health and health inequalities as outcomes of a multitude of interdependent elements within a connected whole'.[29] Complex systems are characterised by three main properties; emergence, feedback, and adaptation. Emergence refers to properties of the system that 'cannot be directly predicted from the elements within it and are more than just the sum of its parts'. Feedback refers to when a change to the system reinforces more change. Adaptation refers to changes in behaviours as a result of certain interventions.

The complex systems approach recognises public health challenges as being multicausal in nature and doubts the effectiveness of measures designed around single interventions. Taking the example of obesity, it is argued that single interventions, such as exercise on prescription, take a lot of individual agency, do not have a wide reach and increase health inequalities. Rather, shifts across multiple elements of the system that influence obesity are required to have longer term impact. While interventions on this scale might have minimal impact on the individual level, when aggregated on the population level they will drive a much larger change. Approaching a multicausal health challenge with this framework requires one to assess the types of interventions needed, and which points they would need to be implemented, to see if changes in interacting factors could deliver more desirable results on a wider level. This way, interventions become a matter of the depth and reach of their impact on the overall population in question.

Case study: Hertfordshire

The complex systems model has been introduced in practice on the local authority level. Hertfordshire County Council were one of the earliest in England to start analysing health and social problems within the county using this approach[30]. As yet, this approach is not widely understood or accepted as a way of analysis in local government. However, using the systems model has allowed Hertfordshire to analyse and tailor solutions to a number of public health challenges including; mental health education, LGBTQ health, obesity, and sexual health. Planning a complex system approach requires decision making rooted partly in scientific method and pragmatism. For example, tackling issues confronting the LGBTQ community requires interventions on the individual and community level. This would involve interventions aimed at strengthening resilience on one hand, while implementing wider interventions that tackle stigma and build services which genuinely understand the community's concerns[31]. Tackling things in such a way requires taking on a levels approach, whereby one looks at the interventions possible at each level of the system; Environmental/Organisational, Interpersonal, and Intrapersonal. As one public health professional stated, 'Most public health problems are rarely only biological, or intrapersonal, or social, or organisational; they are usually a mix of all of them and, need to be treated as such'[32].

29 Rutter, H. et al. (2017) The need for a complex systems model of evidence for public health

30 Localis Interview

31 Localis Interview

32 Localis Interview

Challenges have been noted in working with a complex system model on a local authority level. This model is still new and until recently it was only being discussed in academia. There is also yet to be a large injection of funding into initiatives or pilots that take this approach. The promised social care green paper is slated to look at social care more broadly, and at integration between health and social care services[33]. We recommend that the need to fund the joining-up of services is prioritised in the paper. There is a clear fiscal case for investing further time, money, and effort into developing the approach at the local authority level. One proposal has been to 'set up a project and run it properly with programme management, e-learning, webinars and various other learning tools'[34] as a way to encourage best practice sharing across the country. In furthering the use of this model in local government, there needs to be the strong political will to coordinate between the central and local state.

1.5 Prevention in action: the HENRY initiative

The Health, Exercise, Nutrition for the Really Young (HENRY) programme in Leeds has been a major success story in tackling childhood obesity through coordinated efforts of local services focused on delivering preventative measures. The charity was formed in 2007 after the need for a more preventative approach in dealing with the increasing challenge of childhood obesity was identified. Since then, HENRY have gone on to work with over 10,000 health and early year practitioners while also collaborating with regional NHS trusts, local authorities and various other partners from civil society[35].

The programme is an eight-week course that is delivered in children centres in deprived areas across 36 local authorities. The sessions, designed to be fun and interactive, are delivered by local healthcare practitioners trained by the charity, or by HENRY staff themselves[36]. The foundational belief of the programme aligns with a complex systems approach, whereby simply providing isolated interventions on one level of the system is not enough. Childhood obesity, with all the challenges and solutions associated with it, needs to be viewed holistically. This is especially true for parents who face multiple challenges raising children in socioeconomic deprivation[37]. The programme aims to focus on providing children the healthiest start to life. Grounded in its holistic approach, this entails interventions on all levels, centred around the child in its home and community environment, as well as the emotional wellbeing of the family. Measures include behavioural change strategies, improving knowledge of more nutritional foods, and instilling an authoritative style of parenting.

The programme has been at the heart of Leeds City Council's obesity strategy since 2009. In 2019, Leeds drew national coverage[38] for being the first city in the UK to report decreased childhood obesity. Before this, Amsterdam had been the only city to report such a cut. The most deprived areas saw a drop from 11.5% to 10.5% over a period of four years, and between 2016-17, 625 fewer children in reception were obese. Overall, the city saw a reduction from 9.4% to 8.8%. This success has not been reported in other cities. The success in Leeds was only possible through a collaborative effort between the council's public health and children's services teams working together. According to council leader Cllr Judith Blake, the results from the most deprived areas are particularly important given the councils ambition to fight health inequalities[39]. Ultimately,

33 House of Commons Library (2019) – Social care: forthcoming Green Paper

34 Localis Interview

35 HENRY – About HENRY

36 British Journal of Obesity (2015) - HENRY

37 British Journal of Obesity (2015) - HENRY

38 The Guardian (2019) – Leeds becomes first UK city to lower its childhood obesity rate

39 The MJ 'pluggedin' – Cllr Judith Blake Thursday 9 May 2019 page 12.

it was owing to investment and strong local leadership that the city's work with HENRY has shown results and started to save the council money in the long run.

The example of HENRY in Leeds demonstrates how certain ideas of the complex systems model, while being relatively new, are already being adopted and applied in different ways by local authorities across the country. The success of HENRY clearly proves that there is no reason why programmes like this should not be rolled out across the country. However, in taking the reins to fight these challenges and invest in these initiatives, local authorities need to be given a coherent and comprehensive finance settlement that is fit for purpose. One that is set on longer cycles of ten years, to facilitate better planning[40].

1.6 Supporting joined-up systems through a Prevention Premium

The real-world and academic evidence laid out in this chapter makes a clear case for the benefits of a joined up and comprehensive prevention strategy, both in terms of financial sustainability and population health results. In increasingly lean times, however, it is asking a lot of public health departments which are already suffering from severely reduced grants, to engage in system-wide analysis when merely 'keeping the lights on' is becoming a realistic area of concern.

For this reason, we recommend that – in addition to the public health grant – local authorities with a public health duty be provided with a Prevention Premium, modelled after the Pupil Premium grant for school funding, to help support the transition to public health delivery interlinked across all council functions and wider civil society actors and institutions. The premium would be calculated based on demographic factors, reflecting the different pinch points for public health.

With prevention premium money ringfenced to either hiring new staff or expanding the role of existing officers to focus on strategic coordination, efficiency savings could be made which would lead to savings and better use of the public health grant itself.

1.7 Calculating Preventative Care funding

There are multiple lines of data available which can give an impression of the current and projected state of population health in the UK's local authorities. For the maps below – following Public Health England – we have separated some exemplary indicators into Wider, Lifestyle and Environmental determinants of public health. For the latter, we have used Public Health England's Access to Hazards and Harm index. The scores are produced using a standardised score taken from all the indicators, evenly weighted. In a system where a prevention premium was provided in a similar way to the pupil premium, these maps indicate where money would be most needed. The full scorecard and details of all the indicators used can be found in the appendix. These maps are not intended to provide a definitive measure of preventative care demand, rather to demonstrate the breadth of information available and the geographic disparities across the data.

40 For more info on longer comprehensive finance settlements please see Hitting Reset

Stage	Indicator	Definition	Source
Wider determinants	Unemployment rate	Percentage of the working age population who are claiming Jobseeker's Allowance plus those who claim Universal Credit and are required to seek work and be available for work.	Department for Work and Pensions
	NEETs	Percentage of 16-17 year olds not in education, employment or training or whose activity is not known.	Department for Education
	Children in low-income families	Percentage of children under 16 living in families in receipt of out of work benefits or tax credits where their reported income is less than 60% median income	HM Revenue and Customs
	Over-65s	Percentage of the population over the age of 65	ONS mid-year population estimates
Lifestyle factors	Smoking prevalence	Prevalence of self-reported smokers	Annual Population Survey
	Childhood obesity	Prevalence of obesity (including severe obesity) of children in year 6	NHS Digital, National Child Measurement Programme
	Physical inactivity in adults	The number of respondents to the Active Lives Survey doing less than 30 minutes activity per weeks, as a percentage of total respondents aged over 19	Public Health England
	Substance abuse among young people	Directly standardised rate of hospital admission for substance misuse, per 100,000 population aged 15-24	Local Authority Child Health Profiles/ Public Health England

Figure 1: Preventative care demand by local authority

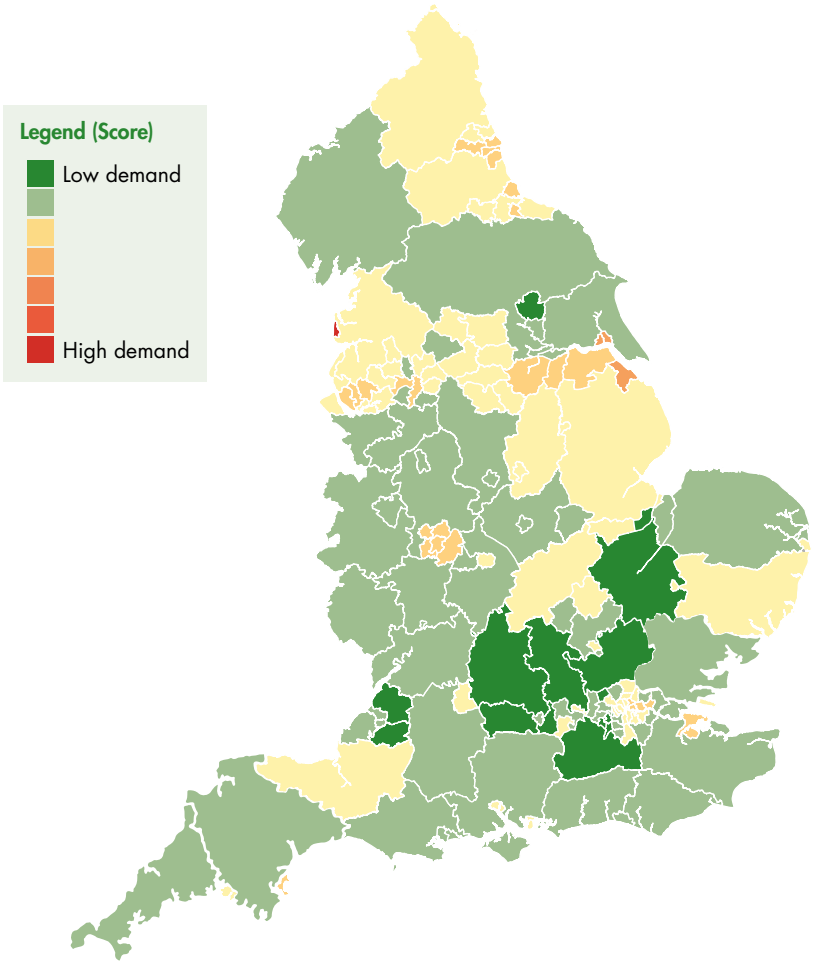


Table 1: Top 10 places for preventative care demand

Number	Place
1	Blackpool
2	Kingston upon Hull, City of
3	North East Lincolnshire
4	Middlesbrough
5	South Tyneside
6	Hartlepool
7	Sunderland
8	Wolverhampton
9	Medway
10	Knowsley

Figure 2: Preventative care demand: wider determinants of public health measures

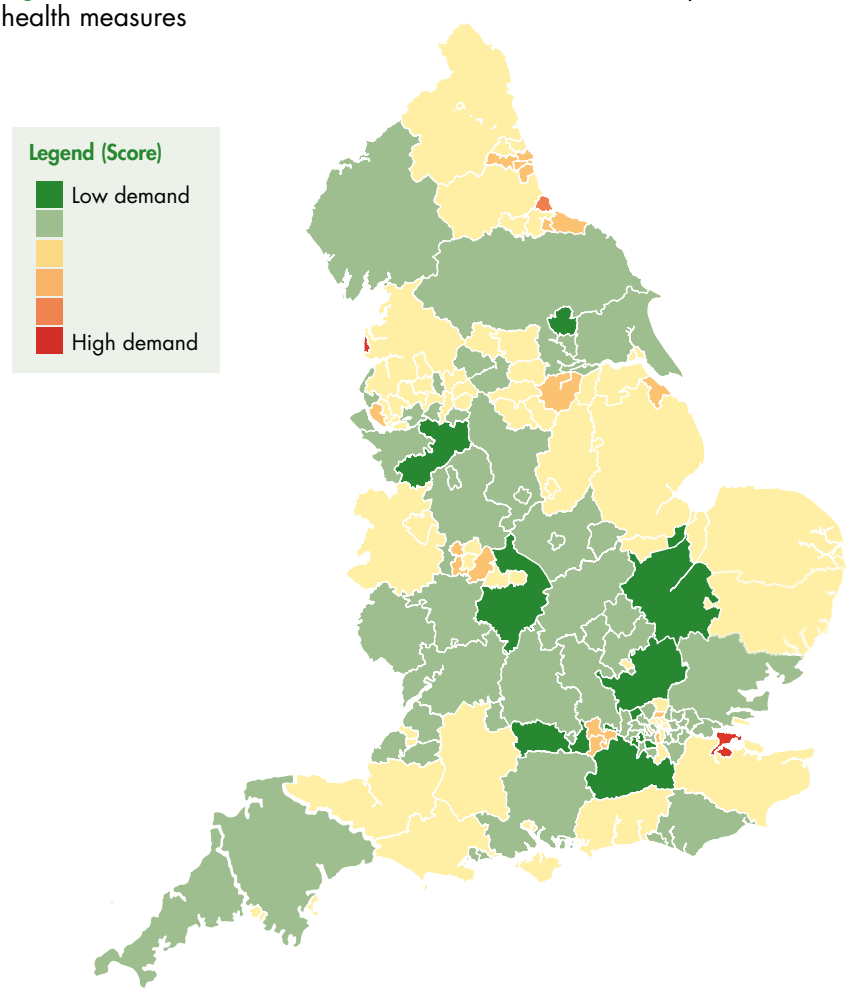


Figure 3: Preventative care demand: lifestyle factors measures

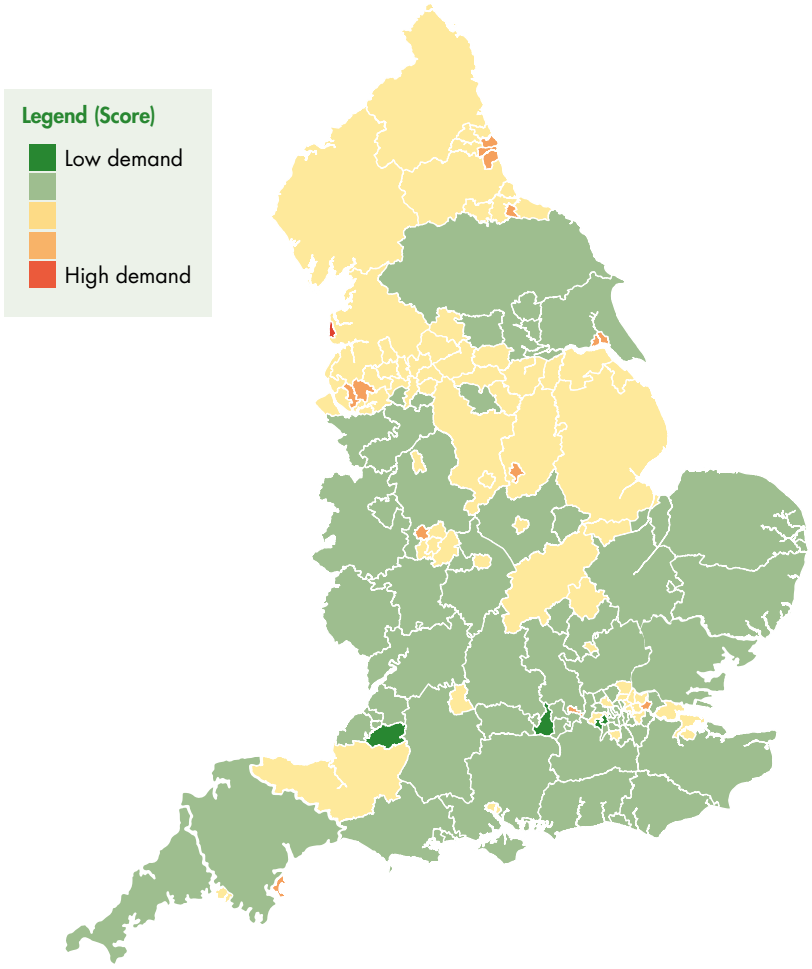
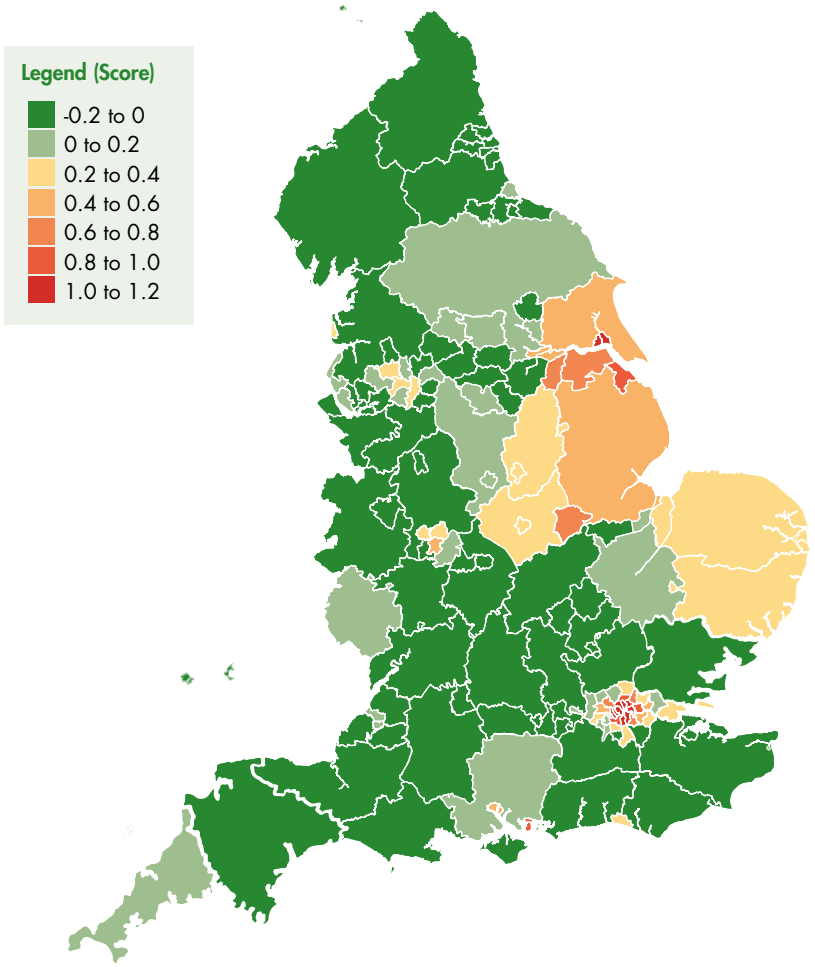


Figure 4: Preventative care demand: 'Access to Hazards and Health Index' measure



1.8 Chapter Recommendations

- **We reiterate our call for local authorities to be given a coherent and comprehensive finance settlement that is fit for purpose and responsibilities**. One that is set on longer cycles of ten years, which would facilitate long-term planning of a place-based prevention agenda.
- **In addition to the public health grant, upper tier local authorities should be provided with a Prevention Premium, modelled after the Pupil Premium grant for school funding, to help support the transition to public health delivery interlinked across all council functions and wider civil society actors and institutions**. The premium would be calculated based on demographic factors, reflecting two pinch points for public health. On the one hand, the rate at which the population is ageing and on the other the prevalence of child poverty.
- **The new government should work toward releasing the Social Care Funding Green Paper at the earliest convenience: the paper itself should contain guidance on the joining-up of services to create holistic public health strategies as a form of preventative care.**

2. The Role of Place in the NHS

This chapter turns to focus on models of NHS delivery which are relevant to place-based health and the local state: consumer-led healthcare, locally-delivered healthcare and integrated healthcare. Incorporating expert analysis from healthcare professionals (the full extent of which can be found in the Annexe), each model is evaluated from a practitioner's perspective and placed in the context of the health service at large.

2.1 Consumer-led healthcare

The other side to the coin of the local authority role in public health is the self-responsibility of individuals to look after their own health. The state must provide an environment that promotes active health. An environment that gives access to a healthy lifestyle, and education on how to achieve it, should be attainable through the right coordination of local services. Within such a system, fitness and wellbeing does not favour the wealthy in society; rich and poor alike can take more exercise, eat more healthily and develop personal networks for emotional support to improve mental health.

Government needs to become more serious about developing and encouraging consumer-led healthcare, focusing on methods for disease prevention and reducing demand by incentivising individuals to look after their own health better. Government policy needs to be saying unequivocally that there is an expectation on us all to think about our fitness and wellbeing, but also to ensure that the public are aware that there is the opportunity of reward and personal benefit for pursuing a healthier lifestyle. The public cannot expect to abuse their health, make a small contribution to tax and then be 'repaired' by the NHS. A fundamental change in attitude from repair to prevent will be vital.

Funding consumer-led healthcare

Challenges

The funding of programmes to promote and encourage consumer-led healthcare must critically consider the ongoing accruing value of such enterprises.

Currently, the major challenges are to:

- clearly demonstrate that capital investment leads to a significant reduction in future healthcare costs;
- identify funding streams that will support projects and posts;
- make the clear financial case for funding additional health economists capable of evaluating how demand-reduction affects NHS budgets.

Coordinated public health strategies of the kind described in chapter one, focused on prevention and taking a systemic approach, can engage the entire population so that individuals come to recognise that they, ultimately, have prime responsibility for managing their own healthcare.

Benefits

Clearly, reducing the risk of developing single or multiple chronic conditions with ensuing comorbidities will benefit the individual, their family, the workplace and society in general. Overall reduction of disease episodes and duration thereof will relieve pressure on NHS budgets and staff, free up key resources and facilities and decrease the number of days that people are absent from work due to illness.

The NHS will enjoy direct financial benefits from cost-reductions across a range of services, including in-patient episodes, pharmacy budgets, GP and outpatient appointments, district nurse services and service provision (pathology, physiotherapy, imaging, dietetics).

As recognised by HENRY in Leeds, when the responsible adults take ownership of their health, they will often become positive role models for children, dependents and have an influence on their close community. Within some families, breaking the cycle of multiple generations needing to rely on the state for treatment of chronic healthcare conditions leading to benefits payment must be broken. Parents have a duty to educate themselves and their children about the benefits of a healthier lifestyle. In addition, reducing the numbers and duties of family carers will prevent individuals having to take time off work commensurate with the reduction in disease episodes. A healthier, fitter workforce will most likely lead to increased tax revenues, higher productivity and reductions in benefit payments.

Healthcare companies can also benefit from increased market exposure and future sales by pump-priming services to the individual to allow them to monitor, test, and self-diagnose. For example, providing kits for Chlamydia testing which are available free of charge for 16-24 year olds. Initiatives supported financially by healthcare companies or the fitness industry, that allow individuals to gain material benefit as a response to taking up healthier activities or altering their deleterious lifestyle gives huge marketing opportunities to those commercial enterprises.

Companies will reap the additional benefits of improving their productivity by developing a more stable and healthier workforce. Some charitable organisations operating within the healthcare sector have to divert much of their funding and resources to support individuals with chronic conditions developed as a result of poor lifestyle choices. We believe that there is a growing expectation that the consumable spending of charities should be allocated to the most deserving causes and that a drive to encourage self-managed healthcare will allow this.

Staffing consumer-led healthcare

Challenges

Development of consumer-led healthcare will require improvements to current networks within the community to achieve autonomy in decision-making, while still working in collaboration with existing healthcare providers. The establishment of a number of additional posts would be necessary in the following categories:

- Health economists;
- Community and workplace health advisors (diet, exercise, lifestyle, drug compliance);
- Monitors and facilitators working with individuals or groups to promote and track changes in lifestyle;
- Data managers and statisticians to collect, store, analyse and share data;
- Marketing specialists to work with business and develop links between the NHS, the community and the commercial healthcare and fitness sectors.

Benefits

Expansion of markets for healthcare and fitness businesses should allow a combination of funding from government and the commercial sector to support new posts, leading to higher employment.

The improvement in the general health of the population should lead to significant reduction in pressure on NHS staff working centrally, across regions and locally within CCGs, Trusts and GP practices with fewer episodes of work-related stress reported.

Innovation in consumer-led healthcare

Establishing and developing a new model of consumer-led healthcare will be challenging, especially in trying to sell the concept that making healthier lifestyle changes can lead to individuals or groups gaining some privilege or material benefit. One of the key tenets that must underpin this bold initiative, is that the model should not be seen as politically contentious, but capable of attracting universal cross-party support, in the way the early intervention agenda has done. This is why the prevention premium, and its depoliticisation through a transparent formula, is vital to public health.

In order to develop robust, active networks to target health interventions to pre-identified communities, it will be essential to tailor local health activities to the community demographic – funding for which would be aligned through the prevention premium. For these initiatives to function efficiently within this consumer-led healthcare space, and make a real difference to the health of the population, knitting the following aspects of the project together becomes a critically important task for the local state:

- Finding local champions and mentors;
- Working with education in schools, Further Education and Higher Education colleges;
- Targeting specific groups with lifestyle and healthcare advisors;
- Engaging with religious and cultural associations;
- Ensuring monitors and facilitators are following up connections made to promote and track lifestyle changes;
- Using marketing specialists from businesses to advise and collaborate with NHS administrators at national, regional and local levels.

Examples of incentives for promoting lifestyle changes might be to reduce individuals' prescription fees or to give vouchers for products for those engaged in treatment plans also involving regular exercise or improved diets (e.g. lowering their fat, sugar and alcohol intake, giving up smoking). As such there is a significant role for the food, drink, and tobacco industries to facilitate taking these issues forward. While a step has been taken in this direction with sugar content of carbonated drinks being recently reviewed, and the implementation of minimum pricing for alcohol in Scotland, there is still a lot more that needs to be addressed.

2.2 Locally-delivered healthcare

In considering how to deliver health services optimally, it is important to review what the role of community care at home, local clinics, district hospitals and specialised regional centres should be. Whilst the NHS gains huge strength from its networking capability, its facilities and a standardised approach to working, one of the drawbacks of being a national health service is that for the most part the same standard and quality of service is expected to be delivered across all conditions, for all demographics and with all infrastructures. Whilst ideally, that

standardised one-size-fits-all model is a laudable goal, it wrongly tends to assume that for the most part all areas of the country and the patient population treated, come from the same starting position and have the same transport links, family and community support, work and home lives, knowledge and expectations, and access to specialist services. Government has started to address this issue and, as an example, announced recently the establishment of early diagnosis centres for cancer, where patients at risk of developing cancer, or with early signs of the disease, can attend a centre which can provide all the tests and scans required under one roof on one day. This is a start, but having early diagnosis centres in all large towns and cities is probably unrealistic given the costs of buying and maintaining new test equipment and scanning devices.

There is a lot that can, and should, be delivered effectively in a standardised way across the country. This includes dispensing, immunisations, and basic monitoring and investigative tests. At the other end of the spectrum, a specialist quaternary care environment has to be used to deliver the highly advanced levels of specialised medicine, monitoring and care required to undertake clinical trials of experimental medicine, and for specialist surgical and medical interventions using hi-tech equipment and trained staff. The establishment of early diagnosis centres for cancer is to be praised, and we expect other examples of concentrating specialist facilities to address other disease settings and conditions. But, to deal with further subsets of medical conditions for different patient populations, devolution of local decision-making to a group of extremely experienced managers of healthcare needs to happen.

CCGs: how local is local?

Currently, Clinical Commissioning Groups (CCGs) are tasked with commissioning and ensuring the delivery of healthcare, locally. But is that really local? Since 2013 and their establishment as 213 groups, various mergers have occurred with more planned, such that by the end of this year there could be only 174 CCGs. Some of these, such as the NHS Birmingham and Solihull CCG serve as many as 1.2 million patients. They have good experience now, and quite rightly are directed to follow NHS England statutory guidelines for routine practice. But, in terms of how they handle conflicts of interests around changing service delivery or introducing changes, they can become hamstrung. In addition, the greater the population that any CCG serves, the less focused they can be on the needs of individual groups. Innovative and sophisticated thought-processes will be required so that the best use of truly local facilities and staff can be deployed to address the health, cultural and social needs of the community. Those needs can vary dramatically for patient groups with different ethnicities, religious faiths, socio-economic backgrounds as well as the unique rhythms and pressures of domestic and working lives. In addition, the workload and demand for particular services within any community can at times escalate unpredictably - disease epidemics, implementation of new processes, or reacting to a change in health dynamics brought about by local demographic shift can all alter requirements dramatically - and increase the immediate pressure on the system.

It would be nice to think that the delivery of healthcare can always be a simple and smooth process, one by which people's normal condition can be maintained or defects rectified at times so they can get back on the road to health – much like we take our cars into the garage for a service. The reality is very different and perhaps we should start to think of how we react to symptoms of serious disease more like we do for accident and emergency or epidemics. It is not just about putting out fires, because as with natural disasters, damage to infrastructure and inevitably sometimes loss of life are the knock-on effects for patients and health services that have to be addressed. As an analogy, In the United States of America, if individual states cannot respond to a disaster because its effects overwhelm state authorities and local resources, they

can apply for Federal Emergency Management Agency (FEMA) aid that can deliver funding, services and experts to address the immediate needs of the local population. Perhaps, for many health issues around the country that have many different causes, we need to be able to divert resources quickly to address the problems of individuals, groups or communities in a way that might be appropriate in one area and not in another. The NHS has to become more flexible in the way that it responds to healthcare demands and we must begin to trust local managers to deliver best care as they see fit in the area or region that they know well.

The business case for locally-led healthcare.

Innovating at local level can involve a huge range of changes to process, from the most simple to extremely complex. Building a robust business case to show the value of any new process or introduction of novel tests and procedures needs to be undertaken. For that to happen, establishing links to other local expertise (financial, managerial and technological) is vital. This presents the refrain of this report – interlinking services across silos at the local level – in a different but equally important light. If CCGs were better aligned with local authorities – as we have recommended previously[41] – they could act as a nexus for bringing together local expertise in decision-making. A more autonomous workforce acting in the community at a truly local level can devise and advise on the potential for innovation.

2.3 Integrated Healthcare

All governments these days purport to achieve a proper system of integrated care that covers medical, clinical and surgical practice and mental health and social care services in primary and secondary healthcare settings. In England, Integrated Care Systems (ICS) are forming to lead integration on the local level. Moreover, NHS England, under their 'Integrated Care' strategy, have established 50 vanguard sites to provide care differently, with NHS organisations and local councils joining forces to coordinate services around the whole needs of each person. However, this idea is still in its infancy and specialist knowledge, and existing successful models are not easily found. What is clear is that in order for an ICS to work, each patient case must be assessed separately on its own merit. This includes assessing aspects relating to the patient's mental health, housing condition, socio-economic circumstance, and relationship with their family and friends in deciding how best to deliver their healthcare. Currently, the NHS is not set up to achieve optimal care across all these areas for individual patients, even though there are teams of social care and occupational health workers who support Hospital Trust Departments at certain centres, especially where disability or old age complicates hospital discharge. What must be addressed are not only the causes of disease, but what allows the course of any condition to worsen and have debilitating, and in some cases, life-changing effects. It is anticipated that the data accruing from the 50 vanguard sites will inform how to effectively establish an integrated health, mental and social care package that can be used to serve local communities, to prevent disease and to reverse the poor levels of fitness and wellbeing amongst all age groups and across all social strata.

There is great potential for coordinated space and estate management in the NHS. Given its vast portfolio of real estate, efforts should be made to see how different healthcare professionals from across the NHS can work together within the same physical space. This style of integration would be personalised, where staff can communicate and coordinate more immediately in deciding what the best course of action for a patient would be. For the last year or so there has been an increase in the number of direct patient care staff, nurses, and even surgery-based pharmacists working within GP surgeries[42]. The Streatham High GP clinic in London

41 Localis (2019) – Hitting Reset

42 The Health Foundation (2019) – A critical moment: NHS staffing trends, retention and attrition

is a good example, where a mixture of GPs of varying seniority, two nurses and a physiotherapist work within the same space[43].

Integrating from all sides

Responsibility for integration should not lie solely with the NHS. Dementia is a good example of a condition where integration from all sides can benefit patients and their families. There are over 670,000 people living with dementia in England[44], who are faced with navigating a largely disjointed care service landscape post-diagnosis. The services required range from speech and language therapists to social workers to name a few[45]. The confusion of this results in unnecessary A&E admissions, with 25% of hospital beds taken by people with dementia[46]. Not only does this have a negative effect on the mental health and autonomy of the patient, it also causes lasting strain on hospitals. Patchy post-diagnoses support and lack of accessible local services results in inadequate support for dementia patients. Recognising the problems this poses, Alzheimer's Society has argued for dementia advisors to provide personalised one-on-one support for patients and carers. Having someone to support you through the post diagnosis process has a range of benefits for patients and the local health and social care system. This includes a reduction in the use of mental health services and increased knowledge and awareness, which allows more independence, and opens access to non-hospital based support when needed. The end result is patient empowerment and better management of public resources.

Health and Wellbeing Boards (HWBs) are another forum for integration. They are relevant as they are a committee of the local authority. They have a statutory duty to work with the CCG to formulate a health strategy for the local population[47]. Dialogue on developing coherent health strategies should incorporate stakeholders outside of local authorities and the NHS. Local business sits at the heart of vibrant communities, and thus they have an interest to ensure the local population is healthy. This is especially true for Local Economic Anchors (LEAs), defined as an area's major employers, rooted in a place and often synonymous with it. LEAs are critical to inclusive and local growth, a key enabler of which is a healthy population. Given this, LEAs have a key role in public health. A perfect example is the ageing population. As people are expected to live longer, they are also expected to work longer. Within this context, LEAs can play a supportive role to ensure provisions are in place that facilitate better conditions for older employees. This involves having a shared approach and coordination between the local health and social care sector, local authorities and the LEA. It makes sense for business to have a seat at the table on the HWBs. This would provide LEAs with an opportunity to take a new approach to Corporate Social Responsibility, one that embodies responsible business and recognises that Local Industrial Success = Business Productivity + Place Prosperity[48].

Managing integrated care systems

The NHS and local authorities are quite operationally and culturally different. The main difficulties will be in aligning the NHS with councils to manage budgets and allocating staff to patient need, requiring new ways of working. There is

43 The Streatham GP Clinic – Streatham High Practice

44 Alzheimer's Society (2016) – Dementia advisers: A cost effective approach to delivering integrated dementia care

45 Alzheimer's Society (2016) – Dementia advisers: A cost effective approach to delivering integrated dementia care

46 Alzheimer's Society – Integrated care for people with dementia

47 The Kings Fund (2016) – Health and wellbeing boards (HWBs) explained

48 For more please see Prosperous Communities, Productive Places

also the issue of the relative newness of ICSs, and concern has been raised over how involved local authorities are. Managing budgets and allocating costs across different aspects of individual patient care is challenging for managers. What the role of CCGs would be in commissioning this complexity of services, how budgets are agreed and who pays, all needs critical discussion. It is important to also consider how to include checks and balances with regard to democratic accountability, ensuring that the public's democratic leverage on local authorities extends into their integrated care roles.

The limited formal power of HWB's could pose certain challenges for decision making, therefore efforts should be made to bolster and clearly define them, while also granting certain executive decision-making capacities. This would of course further increase the need for transparency – the presence of local authority members on HWBs provides a degree of democratic oversight but, as with ICSs at large, it is important that this democratic control is supplemented with the availability of transparent information and clear decision-making procedures.

Alterations to the delivery of area-based public services made in developing an efficient ICS will take time to bed in, but through constant review and iterative changes, will begin to bear fruit. Patience will be required from both politicians and the public, and realistic objectives should be set.

2.4 NHS Patient Data – The Jewel in the Crown

Patient histories, presentation and signs, the testing and monitoring of pathology markers of disease, analysis of tissue and liquid biopsies, scanning and imaging, surgical and medical interventions, and treatments and outcomes, all yield huge amounts of important data from millions of individuals each year. The value of access to and use of data has long been demonstrated in the field of epidemiology most notably for improving public health. Major advances have been made in infection control, including prevention of tuberculosis, smallpox and polio, and more recently human papilloma virus (HPV). Despite this major role that the NHS has played, since its inception it has failed dramatically to understand the full value of all the data that it generates and holds, and the information and knowledge that this yields. It is not just the value of the data that is under-leveraged, it is the net worth of the entire NHS network. A modern reformed UK healthcare system must bring in specialist partners within the NHS network including international healthcare organisations, from industry and the commercial sector (including large tech computing companies and experts in artificial intelligence). This will ensure that the NHS is able to leverage money and support from its massive data warehouses. Small but significant steps have been taken in this direction with some trusts[49] working directly with Google to store and analyse data to allow immediate action for patients at risk, using a secure mobile application called '*Streams*'. *Streams* can send an urgent secure smartphone alert to the right clinician to help treat conditions. That alert is created from existing data records and latest tests to flag up results that show the patient is at immediate risk of acute kidney injury or sepsis.

Another big initiative being developed with the goal for easy data sharing is the Local Health and Care Record Exemplars (LHCRE)[50]. The aim of this is to nurture an environment where information sharing is widely used to tailor care around the specific needs of the patient. The LHCRE programme, launched in conjunction with the Local Government Association (LGA) in 2018, has looked to build on local leadership, while increasing the ethical sharing of data on the local level to improve patient care, with the idea that through this, benefits would spread quickly throughout England. NHS England and the LGA will do this by designing the standards needed to enable information to be securely accessed across a

49 Royal Free London NHS Foundation Trust – 'DeepMind Health' project running between 2015 - 2020

50 NHS England (2018) – Local Health and Care Record Exemplars

range of different health and social care organisations[51].

Underpinning initiatives like this is the understanding that secure cross system access to data and information is vital for integrated delivery of care. Currently there is no national solution for locating and sharing electronic patient records[52], impeding the delivery of integrated care on all levels. Going forward, it is important to learn from the mistakes of the National Programme for IT (NPfIT). This was an earlier attempt at creating an IT infrastructure that connected general practitioners to hospitals across the country, and created electronic patient records. The biggest obstacle to this was the overreach of a 'centralised authority making top down decisions' for local organisations[53]. Key to the success of the above initiatives will be a localist grounded approach, and end user engagement.

Relatedly, the sharing of NHS patient data will continue to be viewed with more than a little suspicion by the general public with regards its security and anonymity - especially once stored in data warehouses that are external to the NHS. The role of NHS Digital will be crucial over the next few years and how it adapts to the changing world of data analysis and involves itself with 'big data' projects[54]. At the heart of the debate about using patient data is the issue of confidentiality and towards what purpose stored data is put. The Caldicott Report of 1997 led to a set of rules and regulations being established (regulations updated in 2012 and 2016) for application to all NHS processes that deal with patient data. But, those safeguards and rules for confidentiality and depersonalisation of data were brought in at a time before the full potential for utilising medical data to predict outcome and plan treatment were known.

Recent public furore and media storms about how data-analysis companies and social media platforms like Facebook use individual's data and information from their posts to dictate what advertising content (political, commercial, social) is sent to people's accounts, has turned much public opinion against the tech giants and their use of data. It is unfortunate that just when a huge window of opportunity has opened up that could facilitate a transformation in how scientists and computer programmers utilise our medical data to develop models of therapy and diagnosis, public trust of data analysts could not be at a lower ebb. There remains a role for ethics committees to oversee the use of data for medical research and development of systems. Currently, all data captured in GP practices is stored on their clinical computing system, the software provided by commercial digital partners e.g. Egton Medical Information System (EMIS), Vision, and System One. This data is stored centrally in Calculating Quality Reporting Service (CQRS) that in turn informs the performance information required for the Quality Outcome Framework.

Overcoming barriers to using patient data

If patient data is to be used across silos to improve care, it is of paramount importance to deal with the fears and trust of the general public, many of whom believe that allowing their medical information to be accessed means that it can be used nefariously. It will be critical to work transparently with NHS England's Chief Data Officer, and the Caldicott guardians - the senior health professionals who can address the issues of confidentiality for patients and any procedure that affects access to patient-identifiable data.

More collaborative working will also be important. Government, NHS and local officials will need to work more closely with computer science departments at universities and other academic centres, as well as collaborate with the computer industry to develop systems for the storing, mining and analysis of such huge and

51 NHS England (2018) – Local Health and Care Record Exemplars

52 NHS Digital (2018) – The National Record Locator Services

53 Justinia T (2017) – The UK's National Programme for IT: Why was it Dismantled?

54 The Times (2018) – If NHS patient data is worth £10 billion, put it on the balance sheet and save lives too

sensitive databases. There is also a case for extending collaboration with industry to the instatement of joint funding streams with NHS England and multinational technology companies who can utilise developments in hardware, middleware and software, programming, cognitive computing and data analytics. Such funding could lead to the establishment of big data projects to model disease treatment.

2.5 Chapter Recommendations

- **The beneficial role Local Economic Anchors can play in tackling emerging public health challenges should be recognised by giving them, or even Local Enterprise Partnerships or Chambers of Commerce, a seat at the table on Health and Wellbeing Boards**. This would lead to further collaboration between all local stakeholders including the local health and social care sector, local authorities and business.
- **Integrated Care Systems should be funded to employ health economists,** to evaluate public health initiatives within a place and their effect on local NHS demand.
- **Roles should be created within Integrated Care Systems for marketing specialists,** to work with local authorities within the ICS area to develop links between the NHS, the local community and the commercial healthcare and fitness sectors.
- **Constituent local authorities should be given a formalised role to act as conveners for Integrated Care Systems to actively engage with local educational institutions,** to ensure a holistic, joined-up health education system, sensitive to local context, is in place.
- **CCG mergers should be halted and rolled back,** with the aim of achieving parity with local government to ensure the legitimacy of locally-delivered healthcare.
- **Government, the NHS and local authorities must commit to greater collaborative working.** Central to this, these partners must also sensitively and securely unlock greater potential from locally-derived patient data 'the jewel in the health service crown'. This will mean funding to build robust systems for the effective storing, mining and analysis of larger databases including clinical and public health outcomes at appropriate sub-regional level. From this point forward, joint funding arrangements involving NHS England should be put in place, with the goal of analysing the success of health interventions across local public services.
- **In line with existing reforms to public property assets, efforts should be made by managers of the NHS estate to co-locate different healthcare professionals from across the health service** – e.g. GPs, nurses, pharmacists – in modern working environments within the community that support best patient care.

3. Staffing the NHS and Social Care

3.1 The staffing crisis – facts and figures

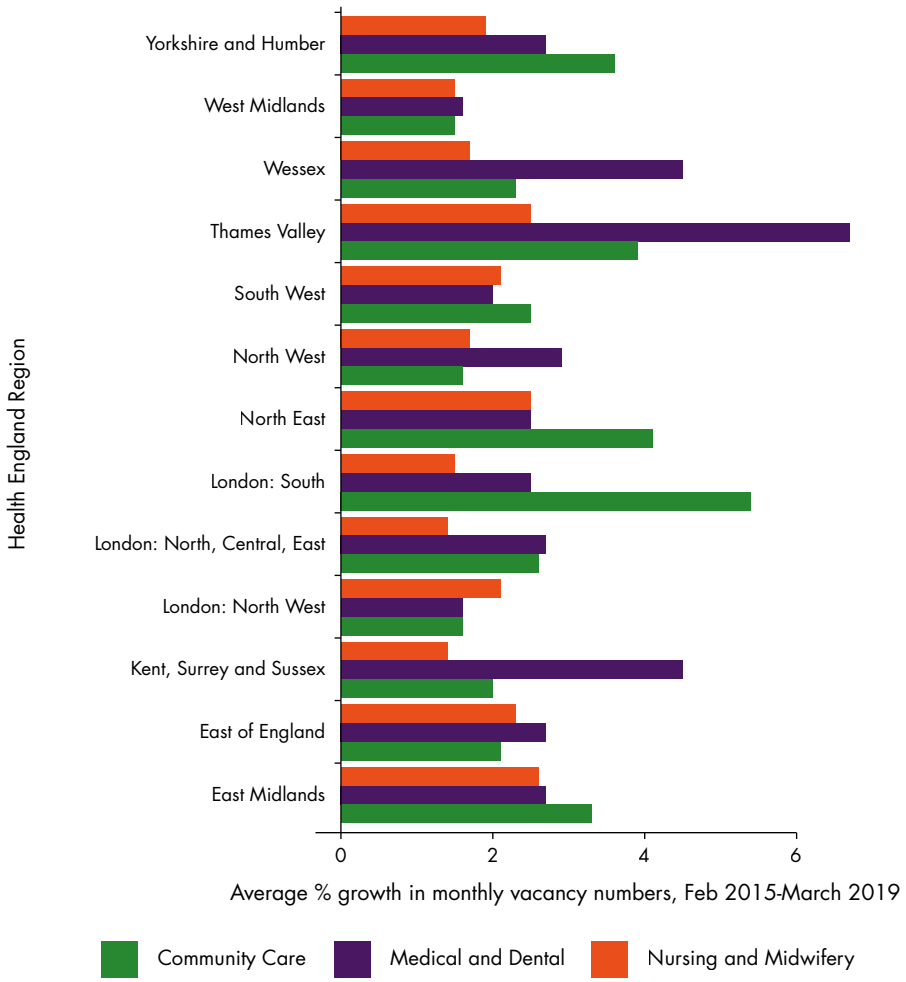
Compounding the myriad issues facing the health sector discussed throughout this report is the worrying level of workforce vacancies it now routinely faces. The NHS is not the only institution facing a staffing crisis; the social care sector also faces huge problems with recruitment and staff retention. Current estimates show that there are more than 100,000 staff vacancies in the NHS, with little chance of training enough GPs and nurses to solve the current crisis[55]. There is also a variation in recruitment of different types of qualified clinical staff. While there has been a growth in the number of hospital-based doctors, there has been a decline with the number of GPs and nurses. Currently, more than 40,000 nursing posts are vacant, which is one in nine posts[56]. This also includes a decline in the number of community health and mental health nurses. The situation with GPs is not any better. Currently, the NHS faces a shortfall of 3,000 GPs, a figure set to increase to 12,000 in 10 years[57]. If we are to achieve the mission of the Ageing Society Grand Challenge, as discussed at the start of the report, we cannot afford a social care staffing crisis of this magnitude. Creating the conditions for people to live independently into old age requires the initial support found through an adequately staffed sector. The question then follows as to how we fix the problem in light of issues like Brexit. The charts below show average growth rates of the number of vacancies in various NHS occupations and regions.

55 BBC News (2019) – NHS has 'no chance of training enough staff'

56 The Health Foundation (2019) – A critical moment: NHS staffing trends, retention and attrition

57 BBC News (2019) – NHS has 'no chance of training enough staff'

Figure 5: Growth in NHS vacancy numbers, 2015-19

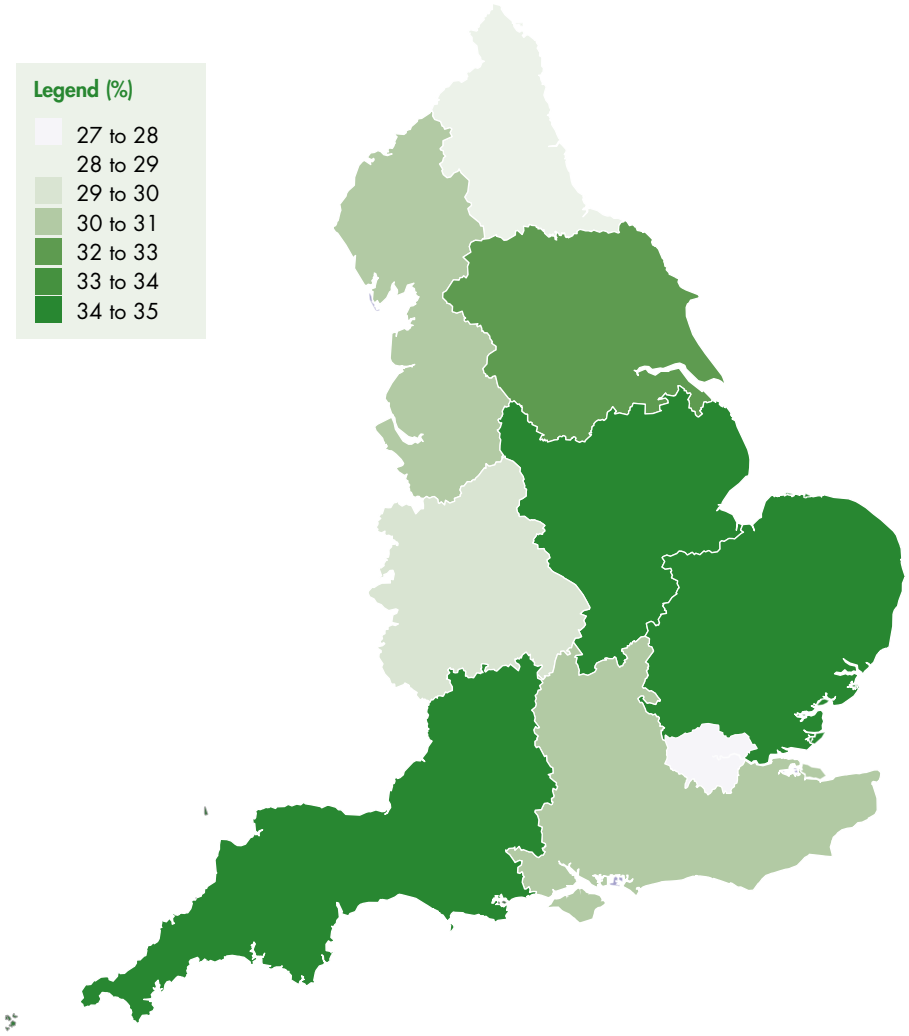


Source: NHS Digital.

With social care, there are currently 1.5 million people working in the sector, but as the population increases and lives longer, in 15 years time there will be a need for an extra one million carers[58]. This is before taking into consideration the similar levels of staff shortages in the NHS. To understand why the issue of staff shortages is occurring in the health and social care sectors, it is important to look at education and training, as well as immigration, and how these two factors impact the overall picture. The map below shows the staff turnover rates of social care workers by UK region.

58 Timewise – Social care crisis: How to keep the carers we have and attract a million new ones

Figure 6: Turnover rate (%) of directly employed social care staff by region



Source: SkillsForCare Workforce Intelligence.

3.2 The migrant workforce and the Health and Social Care sector

Heath and social care has always relied, to varying degrees, on immigration to fill existing staff shortages. Viewing this alongside the demographic changes occurring as a result of internal migration within the UK shows us how certain parts of the country rely on immigration more than others. The increase of people going to university has meant that young adults are moving out of their family homes at a much earlier stage, even if large numbers end up moving back after graduation[59]. ONS data on internal migration reveals that 'most moves occur in early adulthood with the peak age for movers being 19'[60]. This is reflective of a growing trend whereby the younger population of the UK are moving into urban centres to find employment, higher education or other opportunities and in effect creating a 'brain drain' from more rural areas. This raises the median age in rural areas disproportionately compared with urban areas. Thus, with the more knowledge-based jobs and opportunities in cities, which attract a younger, more highly-educated population, rural areas can find it harder to staff health and

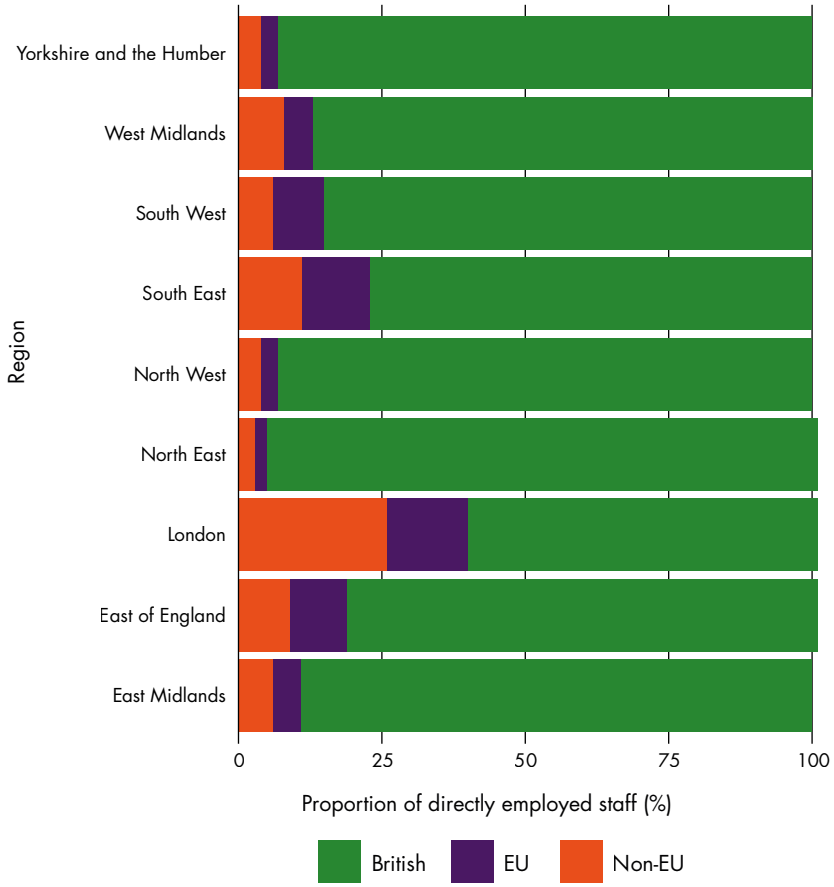
59 The Guardian (2016) – Half of graduates who pay £9,000 tuition fees live with parents

60 ONS (2018) - Population estimates for the UK, England and Wales, Scotland and Northern Ireland: mid-2017

social care vacancies with the homegrown workforce.

Research in recent years has clearly spelled out how EU27 citizens in the UK are 'propping up' the social care sector. Despite EU27 nationals making up 5.4% of the sector's workforce in 2016, there are still difficulties in recruitment and large numbers of job vacancies across the country[61]. One of the biggest recruitment challenges comes from trying to make the sector more attractive to British workers, especially the younger generation. Migrants make a unique contribution to the sector and are doing a lot more than substituting for British labour; they are filling skills gaps that the British population seem unwilling to plug. Restrictions on raising wages, and limited ability for manoeuvring in other aspects of terms and conditions have been raised as factors explaining why the sector faces a staffing problem, and why simply increasing pay won't solve the issue. In all six English regions below the River Trent, non-domestic workers account for at least one-in-ten adult social care professionals. In London and the South East, workers from abroad provide 40 and 23 percent of social care staff respectively.

Figure 7: Adult social care workforce composition by region



Source: SkillsForCare Workforce Intelligence.

A future immigration policy replacing Freedom of Movement would need to take these considerations into account. Migration policy should not intensify the problem by placing obstacles in the way of recruiting the skills and labour the sector needs. Already, ongoing Brexit uncertainty has had an impact on the health and social sector by suppressing the potential migrant workforce[62]. This is understandable, especially considering that most social workers are not paid

61 LSE Brexit Blog (2018) – How EU migrants have propped up Britain's social care

62 Localis Interview

above the national minimum wage and are required to work long hours with no alternative work benefits. If immigrants, who help plug a gap in the sector, do not see any future incentives, it is hardly shocking that British workers themselves are being put off by these conditions.

3.3 Central government response

It is interesting to note how the constantly delayed social care green paper effects local authorities' ability to recruit staff. Originally scheduled for 2017, its purpose was to outline the future of social in the context of The Five Year Forward plan, but councils across the country are still in limbo two years on. The continual uncertainty over the future of funding means council's hands are tied with regard to planning long term in the future; including for a sustainable workforce. The Housing, Communities and Local Government select committee has recognised the challenges facing the social care workforce in terms of high staff turnover and retention problems, which primarily relate to low pay, little career progression prospects, and poor terms and conditions[63]. It has also been noted that the sector suffers from 'a lack of skilled individuals and limited levels of professionalisation in care work'[64]. In an effort to address this problem, we propose that a joint nursing role that combines health and social care work from both settings should be created. This would accelerate steps toward delivering integrated care, give nurses a practical understanding of what this means, and offer concrete career prospects. For example, if you employed people on a rotational basis where they work part time in the community, and part time in the acute setting, you would have a lot more people incentivised to enter the sector. This would allow people more scope and opportunity regarding their career prospects.

The idea to allow staff to explore different aspects of their occupation to increase skills and career prospects is not new. In an effort to combat the staff retention crisis, which runs parallel to staff shortages and has seen more than 200,000 nurses quit over the last nine years[65], the NHS is investing efforts in an employee retention scheme called the National Retention Programme. A key aspect of the programme is the 'transfer window', which allows staff to move within different areas of the NHS to allow for further skills development[66].

There have been huge challenges in the recruitment and retention of nurses. George Osborne's decision to stop paying tuition fees and maintenance grants for nurses in 2015 has been cited as the reason for the vast decline in applications, which has led to the severe shortages now being faced[67]. As with social care, nursing numbers have been helped by EU27 citizens coming to practice in the NHS. However, concerns over Brexit have drastically reduced the numbers coming to the UK. There was a 96 percent drop in nurses from EU27 countries registering between 2016 to 2017[68] It's important to realise the knock on effects this will have. Shortage of staff means nurses working longer hours, enduring higher levels of stress, and experiencing worsening mental health – all of which combine to ultimately affect patient care negatively. In late 2018, the Secretary of State for Health and Social Care told the Royal College of Nurses he would consider legislation that would enshrine safe staffing numbers into law. Yet in July 2019, it was reported that health ministers were not convinced that legislation would bring about positive change[6970]. Regardless, it is clear that the

63 House of Commons Communities and Local Government Committee (2017) – Adult social care: Ninth Report of Session 2016–17

64 Women's Budget Group (2017) – Social Care: A system in crisis

65 National Health Executive (2019) – NHS 'retention crisis' has seen more than 200,000 nurses quit since 2010

66 National Health Executive (2019) – NHS rolls out National Retention Programme to tackle shortages

67 The Guardian (2019) – Cuts may leave NHS short of 70,000 nurses, leaked report warns

68 BBC News (2017) – EU nurse applications drop by 96% since Brexit vote

69 Nursing Notes (2018) – Hancock will 'consider' safe staffing legislation in England

70 Nursing Notes (2019) – Government "not convinced" about safe staffing legislation

status quo is increasingly dangerous for both staff and patients.

In addressing staff shortages, the government has opened 1,500 places in medical schools, in addition to five new training institutions in areas where there are shortages[71]. This is a welcome step, and should be expanded to include social care as well. Importantly, there needs to be a focus on creating training facilities in areas most at risk of the 'brain drain' to urban centres. As identified by a senior adult care commissioner, their rural county does not have a learning facility for social care, meaning any prospective young person ends up going to the nearest city, from which they are unlikely to return[72]. After all the funding cuts for training, it will take a long time to redress this issue. Given that it takes fourteen years to train as a specialist consultant, and that there is a lack of incentives to specialise in areas suffering the highest levels of shortages, we will have to continue to rely on immigration for the foreseeable future.

3.4 Addressing staff shortages: immigration, devolution and fiscal freedom

Taking issues raised here, we agree that a comprehensive immigration system that puts place-based needs first is essential post-Brexit. Importantly, we propose a deal whereby visa quotas per sector are devolved to local government as they are best suited to know the needs for growth in their area. Currently, individual NHS trusts are involved with extensively recruiting from abroad, and the government continues to ease visa restrictions in the health care sector to facilitate this[73]. Surely, local authorities in partnership with local NHS trusts are in a better position to identify their needs and recruit for themselves. Even outside of healthcare, local authorities should identify key sectors where immigration is needed and can fill gaps whilst creating incentives for people to take opportunities and work and train in their areas.

The immigration element of health and social care staffing dovetails with the training of domestic workers when considered as an issue of decentralisation. Local authorities in the most centralised state in the OECD have very little power to influence their own labour markets, through training or through attracting talent from abroad. In recent years, the introduction of Local Enterprise Partnerships, followed by Local Industrial Strategies, along with the gradual devolution of powers to mayoral combined authorities, have shown a gradual acknowledgement from central government that places in England require economic development and can drive it themselves. In systems where local government has greater power over its destiny, approaches to immigration vary according to economic circumstance, demographics and institutional need to name just a few factors[74]. Given the difference in demand outlined in Section One and the need for a more decentralised NHS stated in Section Two, more local control over how visas for health professionals are distributed is a natural conclusion of this research.

Efforts should be doubled to reverse the fall in numbers of nurses, GPs, and other health and social care professionals through a focus on increased homebased training. An obvious start should be reversing the decision to abolish bursaries for nursing students. More institutions and places to study medicine should be made available, with clear incentives laid out for training in specialities where there are current shortages. This could involve having clearly laid out opportunities for an upward career trajectory to boost morale. Again, there is no reason that this ought be done in a command-and-control manner from central government. These steps would be best taken at the local state level: upper-tier

71 i News (2019) – The NHS is facing a staff shortage crisis that could mean it has 250,000 vacancies in a decade

72 Localis Interview

73 ITV (2018) – NHS to recruit thousands more foreign doctors and nurses as visa cap lifted

74 Graeme Boushey and Adam Luedtke (2011) - Immigrants across the U.S. Federal Laboratory: Explaining State-Level Innovation in Immigration Policy

authorities are already well placed to coordinate action on skills and health[75], these functions could be combined to futureproof social care, providing councils are given the freedom to raise money to do so.

Efforts should also be made to attract more young British people to work in social care, especially in areas which have experienced a brain drain and thus have a higher median age. This involves a necessary boost of investment into the social care budget, which would allow for raising wages – above or in line with the National Minimum Wage - and creating new opportunities and prospects for social workers. This too requires local authorities to have greater control of their finances than the current system allows.

3.5 Chapter recommendations

- **A joint nursing role that combines health and social care responsibilities should be created**. This would accelerate steps toward delivering integrated care, give nurses a practical understanding of what this means, and offer concrete career prospects. For example, by employing individuals on a rotational basis whereby they work part time in the community, and part time in the acute setting, one would develop a range of skill sets, which would allow people more scope and opportunity regarding their career prospects.
- **A comprehensive immigration system that puts place-based needs first is essential post-Brexit. We propose a deal whereby visa quotas per sector are devolved to local government as they are best suited to know the needs for growth in their area.** Local authorities in partnership with local NHS trusts are in a better position to identify their and recruit for themselves. Even outside of healthcare, local authorities can identify key sectors where immigration is needed and can fill gaps whilst creating incentives for people to take opportunities to train and work in their areas.
- **Efforts should be doubled to reverse the fall in numbers of nurses, GPs, and other health and social care professionals through a focus on increased homebased training**. A start should be reversing the abolition of bursaries for nursing students. More institutions and places to study should be made available, with clear incentives laid out for training in specialities where there are current shortages. This should involve having clearly laid out opportunities for an upward career trajectory to boost morale.
- **Efforts should also be made to attract more young British people to work in social care, especially in areas which have experienced a brain drain and thus have a higher median age**. This involves a necessary boost of investment into the social care budget, which would allow for raising wages and creating new opportunities and prospects for social workers.

75 Localis (2019) – Hitting Reset

4. Recommendations

1. **We reiterate our call for local authorities to be given a coherent and comprehensive finance settlement that is fit for purpose.** One that is set on longer cycles of ten years, which would facilitate long term planning of the prevention agenda.
2. **In addition to the public health grant, upper tier local authorities should be provided with a Prevention Premium, modelled after the Pupil Premium grant for school funding, to help support the transition to public health delivery interlinked across all council functions and wider civil society actors and institutions.** The premium would be calculated based on demographic factors, reflecting two pinch points for public health. On the one hand, the rate at which the population is ageing and on the other the prevalence of child poverty.
3. **The new government should work toward releasing the Social Care Funding Green Paper at the earliest convenience, the paper should contain guidance on the joining-up of services to create holistic public health strategies as a form of preventative care.**
4. **The beneficial role Local Economic Anchors can play in tackling emerging public health challenges should be recognised by giving them a seat at the table on Health and Wellbeing Boards**. This would lead to further collaboration between all local stakeholders including the local health and social care sector, local authorities and business.
5. **Integrated Care Systems should be funded to employ health economists,** to evaluate public health initiatives within a place and their effect on local NHS demand.
6. **Roles should be created within Integrated Care Systems for marketing specialists,** to work with local authorities within the ICS area to develop links between the NHS, the local community and the commercial healthcare and fitness sectors.
7. **Constituent local authorities should be given a formalised role to act as conveners for Integrated Care Systems to actively engage with local educational institutions,** to ensure a holistic, joined-up health education system, sensitive to local context, is in place.
8. **CCG mergers should be halted and rolled back,** with the aim of achieving parity with local government to ensure the legitimacy of locally-delivered healthcare.

9. **Government, the NHS and local authorities must commit to greater collaborative working. Central to this, these partners must also sensitively and securely unlock greater potential from locally-derived patient data 'the jewel in the health service crown'.** This will mean funding to build robust systems for the effective storing, mining and analysis of larger databases including clinical and public health outcomes at appropriate sub-regional level. From this point forward, joint funding arrangements involving NHS England should be put in place, with the goal of analysing the success of health interventions across local public services.

10. **In line with existing reforms to public property assets, efforts should be made by managers of the NHS estate to co-locate different healthcare professionals from across the health service** – e.g. GPs, nurses, pharmacists – in modern working environments within the community that support best patient care.

11. **A joint nursing role that combines health and social care responsibilities should be created**. This would accelerate steps toward delivering integrated care, give nurses a practical understanding of what this means, and offer concrete career prospects. For example, by employing individuals on a rotational basis whereby they work part time in the community, and part time in the acute setting, one would develop a range of skill sets, which would allow people more scope and opportunity regarding their career prospects.

12. **A comprehensive immigration system that puts place-based needs first is essential post-Brexit. We propose a deal whereby visa quotas per sector are devolved to local government as they are best suited to know the needs for growth in their area.** Local authorities in partnership with local NHS trusts are in a better position to identify their and recruit for themselves. Even outside of healthcare, local authorities can identify key sectors where immigration is needed and can fill gaps whilst creating incentives for people to take opportunities to train and work in their areas.

13. **Efforts should be doubled to reverse the fall in numbers of nurses, GPs, and other health and social care professionals through a focus on increased homebased training**. A start should be reversing the abolition of bursaries for nursing students. More institutions and places to study should be made available, with clear incentives laid out for training in specialities where there are current shortages. This should involve having clearly laid out opportunities for an upward career trajectory to boost morale.

14. **Efforts should also be made to attract more young British people to work in social care, especially in areas which have experienced a brain drain and thus have a higher median age**. This involves a necessary boost of investment into the social care budget, which would allow for raising wages, and creating new opportunities and prospects for social workers.

Appendix: Scorecards

Note: These tables are *indicative* examples of how a premium may be calculated and are not intended to be comprehensive models. The final 'score' is determined by standardising all indicators using the inter-decile range method and combining them, unweighted.

Total Scores

Place	Wider	Lifestyle	AHAH	Total
Blackpool	3.41	4.90	0.25868	8.57
Kingston upon Hull, City of	0.90	2.45	1.01192	4.36
North East Lincolnshire	1.31	1.81	0.94305	4.06
Middlesbrough	1.56	2.40	-0.05	3.91
South Tyneside	1.95	2.10	-0.1555	3.90
Hartlepool	2.01	1.81	0.01319	3.84
Sunderland	1.78	2.05	-0.1056	3.72
Wolverhampton	1.20	2.04	0.20774	3.44
Medway	3.10	0.09	-0.0354	3.15
Knowsley	0.54	2.64	-0.0736	3.10
Sandwell	0.74	1.69	0.59322	3.03
Doncaster	1.01	1.91	-0.0816	2.83
Nottingham	1.44	1.02	0.36172	2.82
Barking and Dagenham	-0.01	2.23	0.42303	2.65
St. Helens	0.21	2.47	-0.0565	2.62
Tower Hamlets	0.60	0.89	1.13102	2.62
Torbay	0.62	2.08	-0.1391	2.57
North Lincolnshire	0.62	1.24	0.66256	2.52
Manchester	0.84	1.42	0.20203	2.46
Birmingham	1.91	0.31	0.18065	2.40
Salford	0.60	1.45	0.29225	2.34
Gateshead	1.39	1.00	-0.1445	2.25
Walsall	0.88	1.08	0.22581	2.19
Dudley	1.06	1.11	-0.0011	2.17
Liverpool	1.49	0.47	0.18431	2.14
Newham	-0.25	1.42	0.87958	2.05
Hackney	0.18	0.81	1.0228	2.01
Haringey	1.03	0.02	0.91447	1.96
Stoke-on-Trent	0.66	1.44	-0.1555	1.94
Redcar and Cleveland	1.15	0.82	-0.0447	1.92
Lambeth	1.10	-0.29	1.03736	1.84
Kensington and Chelsea	1.23	-0.57	1.1413	1.80
Wakefield	0.50	1.32	-0.0187	1.80
Blackburn with Darwen	0.13	1.71	-0.1188	1.72

Halton	0.17	1.49	-0.0127	1.64
Oldham	0.41	1.20	0.032	1.64
Wigan	0.14	1.40	0.0913	1.63
Rochdale	0.42	1.20	-0.0509	1.58
Southampton	0.30	0.66	0.59333	1.55
Bolton	0.62	0.66	0.26795	1.55
Rotherham	0.68	0.89	-0.0456	1.52
Brent	-0.45	1.22	0.745	1.52
North Tyneside	0.06	1.52	-0.0936	1.49
Bradford	0.57	0.92	0.00662	1.49
Tameside	0.16	1.32	-0.0576	1.43
Wirral	-0.20	1.73	-0.1052	1.43
Stockton-on-Tees	0.49	1.08	-0.1555	1.42
Barnsley	0.63	0.93	-0.1462	1.42
Leicester	0.58	0.68	0.1115	1.38
Lincolnshire	0.75	0.19	0.42543	1.36
County Durham	0.73	0.75	-0.1496	1.33
Peterborough	0.31	1.04	-0.0392	1.31
Southwark	0.72	-0.52	1.02774	1.23
Enfield	0.48	0.41	0.32291	1.22
Derby	0.62	0.48	0.05095	1.15
Luton	0.20	1.05	-0.0923	1.15
Darlington	0.28	0.96	-0.1417	1.10
Islington	0.08	-0.19	1.1413	1.03
Westminster	-0.06	-0.19	1.1413	0.89
Newcastle upon Tyne	0.77	0.24	-0.1404	0.87
Slough	-1.33	2.00	0.18639	0.85
Plymouth	0.49	0.33	-0.0035	0.81
Portsmouth	-0.08	-0.08	0.88461	0.73
Greenwich	-0.17	0.37	0.4496	0.64
Northumberland	0.28	0.38	-0.0302	0.63
Waltham Forest	-0.89	0.79	0.68757	0.59
Lewisham	-0.05	-0.03	0.662	0.59
Coventry	0.06	0.62	-0.0899	0.59
Camden	0.35	-0.82	1.05678	0.59
Somerset	0.50	0.16	-0.0797	0.58
Southend-on-Sea	0.30	-0.08	0.3445	0.57
Nottinghamshire	0.49	-0.28	0.34803	0.56
Lancashire	0.58	0.06	-0.1052	0.53
Kirklees	-0.08	0.67	-0.1118	0.48
Bracknell Forest	1.81	-1.25	-0.1555	0.41
Sheffield	0.52	-0.28	0.08366	0.32

Bedford	-0.34	0.72	-0.0634	0.31
Leeds	0.15	-0.04	0.07197	0.18
Warrington	-0.74	0.92	-0.0167	0.17
Suffolk	0.31	-0.46	0.28396	0.13
Croydon	0.24	-0.36	0.21892	0.10
Sefton	-0.09	0.03	0.1494	0.10
Hammersmith and Fulham	-0.58	-0.43	1.079	0.07
Swindon	-0.32	0.46	-0.0811	0.06
Northamptonshire	-0.32	0.34	-0.0226	0.00
Hounslow	-0.61	0.13	0.37728	-0.10
Thurrock	-0.96	0.59	0.27394	-0.10
Calderdale	-0.15	0.16	-0.132	-0.12
Norfolk	0.17	-0.55	0.25645	-0.12
Kent	0.12	-0.23	-0.0475	-0.15
Derbyshire	-0.45	0.17	0.09809	-0.17
Cornwall	0.03	-0.26	0.0486	-0.18
Telford and Wrekin	0.06	-0.11	-0.1429	-0.19
Isle of Wight	0.35	-0.51	-0.0586	-0.23
Redbridge	-0.65	0.03	0.3905	-0.23
Bristol, City of	0.21	-0.59	0.1166	-0.27
Windsor and Maidenhead	1.35	-1.56	-0.1056	-0.32
Bury	-0.43	0.03	0.04831	-0.35
Wandsworth	-0.14	-1.15	0.87652	-0.41
East Riding of Yorkshire	-0.27	-0.78	0.58611	-0.47
Wiltshire	0.35	-0.72	-0.1062	-0.47
North Yorkshire	-0.31	-0.41	0.08956	-0.63
Solihull	0.22	-0.71	-0.137	-0.63
Staffordshire	-0.23	-0.33	-0.0934	-0.65
Leicestershire	-0.13	-0.79	0.25416	-0.66
Sutton	-0.75	0.11	-0.0306	-0.67
Bournemouth	-0.29	-0.42	0.0337	-0.68
Havering	-0.25	-0.51	0.03451	-0.72
East Sussex	-0.05	-0.59	-0.1069	-0.75
Cumbria	-0.89	0.18	-0.0415	-0.75
Hillingdon	-0.49	-0.34	0.07612	-0.76
Ealing	-0.60	-0.69	0.53325	-0.76
Brighton and Hove	-0.07	-1.03	0.3398	-0.77
Central Bedfordshire	-0.64	-0.04	-0.0876	-0.77
Bexley	-0.62	-0.43	0.22186	-0.83
West Sussex	0.33	-1.06	-0.1098	-0.84
Rutland	-0.99	-0.63	0.7347	-0.89

Shropshire	0.24	-1.12	-0.0142	-0.89
Barnet	-0.66	-0.39	0.10567	-0.95
Herefordshire, County of	-0.45	-0.55	0.01813	-0.98
Milton Keynes	-0.62	-0.33	-0.1326	-1.08
Worcestershire	-0.31	-0.71	-0.0859	-1.10
Poole	-0.56	-0.44	-0.1086	-1.12
Reading	-0.50	-0.65	-0.0622	-1.21
Stockport	-0.93	-0.26	-0.033	-1.21
Dorset	0.00	-1.11	-0.115	-1.23
Cheshire East	-1.05	-0.19	-0.009	-1.24
Essex	-0.63	-0.70	-0.0368	-1.36
Hampshire	-0.75	-0.63	0.00106	-1.38
Trafford	-0.51	-1.02	0.0878	-1.44
Gloucestershire	-0.70	-0.65	-0.1117	-1.45
Bromley	-0.83	-0.68	-0.0722	-1.58
Devon	-0.17	-1.33	-0.0927	-1.60
Cheshire West and Chester	-0.83	-0.73	-0.0677	-1.62
North Somerset	-0.23	-1.37	-0.1226	-1.73
Merton	-1.19	-0.90	0.3071	-1.78
Warwickshire	-1.10	-0.80	-0.0936	-2.00
Cambridgeshire	-1.16	-0.92	0.02556	-2.05
Harrow	-1.28	-1.01	0.04048	-2.25
Kingston upon Thames	-0.95	-1.31	0.00484	-2.26
South Gloucestershire	-0.94	-1.37	-0.0792	-2.39
Hertfordshire	-1.00	-1.27	-0.1236	-2.40
Oxfordshire	-0.74	-1.86	-0.0631	-2.67
West Berkshire	-1.51	-1.13	-0.1437	-2.79
Buckinghamshire	-0.95	-1.84	-0.1334	-2.93
York	-1.13	-1.80	-0.0898	-3.02
Bath and North East Somerset	-0.83	-2.09	-0.1044	-3.02
Surrey	-1.26	-1.88	-0.1425	-3.28
Richmond upon Thames	-1.21	-2.68	0.08081	-3.81
Wokingham	-1.29	-2.41	-0.1555	-3.85

1. Wider Determinants of Health

Place	Unemployment rate	NEETs (% of young people)	Children in low income families (%)	% 65+	WIDER
Blackpool	5.7	18.04	26.2	20.4	**3.41**
Medway	3.9	24.42	18.6	15.7	**3.10**
Hartlepool	9	3.62	28.6	19	**2.01**
South Tyneside	6.5	8.30	26.4	19.9	**1.95**
Birmingham	7.3	9.22	27.6	12.9	**1.91**
Bracknell Forest	2.4	23.96	9.1	14.2	**1.81**
Sunderland	6.1	9.41	23.6	19.2	**1.78**
Middlesbrough	7.4	4.16	31.8	16	**1.56**
Liverpool	4	12.66	26.3	14.6	**1.49**
Nottingham	7	7.01	29.5	11.5	**1.44**
Gateshead	4.7	10.75	20.9	19.3	**1.39**
Windsor and Maidenhead	2.7	19.33	7.9	18.4	**1.35**
North East Lincolnshire	5.7	6.26	26	20	**1.31**
Kensington and Chelsea	6	9.28	20.5	15.3	**1.23**
Wolverhampton	6.9	4.72	26.3	16.7	**1.20**
Redcar and Cleveland	5.3	5.48	25.2	22	**1.15**
Lambeth	6.3	10.09	23.4	8.1	**1.10**
Dudley	5.4	7.15	20.7	20.3	**1.06**
Haringey	5.3	11.55	21.3	9.8	**1.03**
Doncaster	5.6	6.46	22.6	18.8	**1.01**
Kingston upon Hull, City of	5.8	5.47	27.4	14.8	**0.90**
Walsall	5.2	5.79	25.8	17.7	**0.88**
Manchester	5.2	8.75	27.1	9.3	**0.84**
Newcastle upon Tyne	5.4	6.65	24.7	14.4	**0.77**
Lincolnshire	4.5	7.40	16.3	23.2	**0.75**
Sandwell	6	4.75	25.5	15.1	**0.74**
County Durham	4.6	6.30	21.8	20.4	**0.73**
Southwark	5.9	8.67	23.2	8.2	**0.72**
Rotherham	4.9	5.89	21.8	19.4	**0.68**
Stoke-on-Trent	6	4.04	24	16.9	**0.66**
Barnsley	5	5.55	21.9	19.1	**0.63**
Bolton	4.9	7.24	20.1	17	**0.62**
Torbay	3.6	5.27	21.2	26.1	**0.62**

Derby	4.6	7.82	21	16.2	**0.62**
North Lincolnshire	5.4	5.20	18.7	20.7	**0.62**
Tower Hamlets	5.6	6.82	30.3	6.2	**0.60**
Salford	5	7.68	21.1	14.4	**0.60**
Leicester	5.5	7.17	23	11.7	**0.58**
Lancashire	4.4	8.26	15.1	20.4	**0.58**
Bradford	5.1	6.48	23.2	14.6	**0.57**
Knowsley	3.6	7.38	25	17	**0.54**
Sheffield	4.8	6.11	23.2	16.1	**0.52**
Somerset	3.3	8.99	12.9	24.2	**0.50**
Wakefield	4.9	6.08	19.2	18.8	**0.50**
Stockton-on-Tees	5.7	4.24	21.3	17.8	**0.49**
Nottinghamshire	5.2	6.04	15.6	20.5	**0.49**
Plymouth	4.5	6.78	20	18.1	**0.49**
Enfield	5.3	6.67	22.2	13	**0.48**
Rochdale	5.1	5.69	21.2	16.2	**0.42**
Oldham	5.3	5.10	22	15.9	**0.41**
Wiltshire	2.9	11.26	10.4	20.9	**0.35**
Isle of Wight	4	3.32	18.8	27.3	**0.35**
Camden	4.5	6.01	27.3	11.9	**0.35**
West Sussex	3	9.84	11.3	22.6	**0.33**
Peterborough	4.9	6.97	18.8	14.6	**0.31**
Suffolk	3.7	7.38	13.8	22.9	**0.31**
Southend-on-Sea	3.6	7.27	19.1	19.1	**0.30**
Southampton	5.6	5.76	20.1	13.2	**0.30**
Darlington	4.7	4.40	20	20	**0.28**
Northumberland	4.3	4.45	17.2	23.9	**0.28**
Shropshire	2.9	8.66	12.2	23.9	**0.24**
Croydon	5	7.91	16.1	13.4	**0.24**
Solihull	4.2	6.04	15.9	20.9	**0.22**
St. Helens	3.5	6.25	19.5	20.3	**0.21**
Bristol, City of	3.8	8.81	19.7	13	**0.21**
Luton	4.6	7.83	19	12.3	**0.20**
Hackney	6	5.18	24.7	7.4	**0.18**
Norfolk	4	5.07	15.1	24.1	**0.17**
Halton	4.5	5.20	19.6	17.8	**0.17**
Tameside	4.7	5.17	18.9	17.6	**0.16**
Leeds	3.9	6.97	20.3	15.5	**0.15**
Wigan	4.1	7.01	15.1	18.8	**0.14**
Blackburn with Darwen	5.2	4.85	20.7	14.3	**0.13**

Kent	4.4	5.36	16.5	19.9	**0.12**
Islington	5.1	3.50	30.6	8.8	**0.08**
Telford and Wrekin	3.9	5.79	20.5	16.9	**0.06**
North Tyneside	4.7	4.27	17.1	19.8	**0.06**
Coventry	4.6	5.36	21.8	13.8	**0.06**
Cornwall	2.8	5.84	16.4	24.5	**0.03**
Dorset	2.9	5.12	12.5	28.6	**0.00**
Barking and Dagenham	5.9	4.24	22.5	9.4	**-0.01**
East Sussex	2.8	4.88	16.7	25.4	**-0.05**
Lewisham	4.8	6.05	22.6	9.3	**-0.05**
Westminster	4.9	2.77	27.3	12.3	**-0.06**
Brighton and Hove	6	4.46	15.7	13.3	**-0.07**
Kirklees	4.9	3.87	18	17.3	**-0.08**
Portsmouth	4.4	5.36	20.4	14	**-0.08**
Sefton	3.1	4.96	17.1	23.1	**-0.09**
Leicestershire	4.7	5.26	10.9	20.2	**-0.13**
Wandsworth	3.9	9.13	17.2	9.4	**-0.14**
Calderdale	4.1	3.90	19.6	18.3	**-0.15**
Devon	3	5.48	12.5	25	**-0.17**
Greenwich	5.4	4.02	21.8	10.4	**-0.17**
Wirral	2.8	4.90	19.2	21.3	**-0.20**
North Somerset	2.8	6.06	12.6	23.7	**-0.23**
Staffordshire	2.9	6.69	13.2	21.3	**-0.23**
Havering	4.7	3.46	16.5	18.1	**-0.25**
Newham	5.6	5.17	20.1	7.3	**-0.25**
East Riding of Yorkshire	3.4	4.11	12.2	25.4	**-0.27**
Bournemouth	3.6	5.28	16.4	18.1	**-0.29**
Worcestershire	3.1	5.06	14.4	22.2	**-0.31**
North Yorkshire	2.8	6.54	9.8	23.9	**-0.31**
Northamptonshire	3.9	5.78	13.6	17.7	**-0.32**
Swindon	3.8	6.70	14.1	15.6	**-0.32**
Bedford	4	5.08	14.9	17.5	**-0.34**
Bury	4.2	4.04	14.7	18	**-0.43**
Derbyshire	3.4	3.78	15.3	21.3	**-0.45**
Herefordshire, County of	2.7	4.87	12.6	24	**-0.45**
Brent	5.3	3.40	18	11.8	**-0.45**
Hillingdon	4.4	4.91	16	13.3	**-0.49**
Reading	4.1	6.05	15.7	12.1	**-0.50**

Trafford	3.7	6.03	11.6	17.2	**-0.51**
Poole	3.2	3.32	14.4	22.4	**-0.56**
Hammersmith and Fulham	5.5	1.85	20.6	10.6	**-0.58**
Ealing	5.5	2.31	16.9	12.4	**-0.60**
Hounslow	4.9	4.78	13.8	11.8	**-0.61**
Bexley	4	3.43	16.3	16.5	**-0.62**
Milton Keynes	4.3	4.65	15.1	13.4	**-0.62**
Essex	3.2	3.84	14.4	20.4	**-0.63**
Central Bedfordshire	2.9	6.61	11.3	17.7	**-0.64**
Redbridge	5	3.75	14.7	12.4	**-0.65**
Barnet	4.7	3.73	14	14.2	**-0.66**
Gloucestershire	2	6.06	12.6	21	**-0.70**
Warrington	4	3.70	11.5	18.3	**-0.74**
Oxfordshire	2.1	7.76	10.3	18	**-0.74**
Hampshire	2.9	4.82	10.3	21.2	**-0.75**
Sutton	4.7	4.28	9.8	15.2	**-0.75**
Cheshire West and Chester	3.6	2.27	12.7	21.1	**-0.83**
Bath and North East Somerset	3	5.39	9.8	18.9	**-0.83**
Bromley	4.2	2.50	13.2	17.5	**-0.83**
Cumbria	2	3.86	12.2	23.8	**-0.89**
Waltham Forest	4	3.34	19.4	10.5	**-0.89**
Stockport	3	3.09	13.5	19.8	**-0.93**
South Gloucestershire	3	4.72	10.2	18.6	**-0.94**
Kingston upon Thames	4.9	2.77	11.7	13.6	**-0.95**
Buckinghamshire	2.2	6.40	9.5	18.6	**-0.95**
Thurrock	4.1	1.94	17.7	13.8	**-0.96**
Rutland	3.5	2.30	6.5	24.5	**-0.99**
Hertfordshire	3.6	3.54	11.5	16.9	**-1.00**
Cheshire East	3.1	2.24	10.2	22.5	**-1.05**
Warwickshire	2.2	3.76	11.9	20.7	**-1.10**
York	3	3.78	10.3	18.2	**-1.13**
Cambridgeshire	2.9	3.16	11.6	18.6	**-1.16**
Merton	4.3	2.56	13.1	12.4	**-1.19**
Richmond upon Thames	3.8	3.70	8.5	15.4	**-1.21**
Surrey	2.4	4.37	9.1	18.7	**-1.26**
Harrow	3.6	2.07	12.9	15.4	**-1.28**

Wokingham	2.5	5.51	6.4	17.5	**-1.29**
Slough	3.7	3.24	15.1	9.8	**-1.33**
West Berkshire	2.8	2.27	9.1	18.5	**-1.51**

2. Lifestyle Factors

Place	Smoking prevalence	Childhood obesity (at year 6)	Physically inactive adults	Substance abuse hospital admissions - young people	LIFESTYLE
Blackpool	22.3222	22.58	32.44	329.28	**4.90**
Nottingham	19.4379	24.83	22.65	NA	1.69
Knowsley	19.678	24.53	25.68	199.20	**2.64**
St. Helens	16.1112	22.63	26.09	236.27	2.47
Kingston upon Hull, City of	23.0691	23.57	28.45	137.56	**2.45**
Middlesbrough	18.645	22.99	30.54	171.05	**2.40**
Barking and Dagenham	18.6539	29.66	33.65	79.37	**2.23**
Torbay	14.7552	NA	20.01	148.38	**3.43**
South Tyneside	18.3628	24.18	27.09	162.40	**2.10**
Sunderland	22.7455	25.02	27.97	99.12	**2.05**
Wolverhampton	14.4249	27.64	37.10	101.67	**2.04**
Slough	16.6127	26.79	34.18	102.74	**2.00**
Doncaster	19.7291	21.92	29.18	137.17	**1.91**
Hartlepool	19.1947	24.06	29.50	114.52	1.81
North East Lincolnshire	19.9892	21.05	28.70	136.87	**1.81**
Wirral	15.9423	21.56	26.40	183.79	**1.73**
Blackburn with Darwen	16.7455	21.64	30.46	146.19	**1.71**
Sandwell	17.423	28.16	29.58	87.49	**1.69**
North Tyneside	16.5315	20.94	28.95	149.07	**1.52**
Halton	14.9663	23.43	24.17	173.44	**1.49**
Salford	21.2286	22.70	23.91	112.36	**1.45**
Stoke-on-Trent	18.8657	23.59	28.99	94.33	**1.44**
Newham	19.0757	27.37	29.66	54.46	**1.42**
Manchester	22.0035	26.29	22.28	81.91	1.42
Wigan	15.6451	21.10	26.22	164.81	**1.40**
Tameside	17.6457	21.22	25.80	139.50	**1.32**
Wakefield	17.9403	20.51	28.51	123.89	**1.32**
North Lincolnshire	20.8373	22.81	26.15	82.92	**1.24**
Brent	15.7856	27.72	30.48	64.00	**1.22**

Rochdale	17.751	23.80	27.88	92.59	**1.20**
Oldham	16.5533	23.37	29.83	95.29	**1.20**
Nottinghamshire	15.1204	19.01	20.93	NA	0.62
Dudley	13.6963	25.88	29.59	98.55	**1.11**
Stockton-on-Tees	15.0018	21.50	26.65	139.35	1.08
Walsall	14.4897	25.60	26.98	107.10	**1.08**
Luton	14.3171	24.65	28.01	107.39	**1.05**
Peterborough	17.6127	20.75	24.71	127.76	**1.04**
Gateshead	16.5012	22.91	23.20	127.56	**1.00**
Darlington	14.4465	21.25	27.38	131.99	**0.96**
Barnsley	18.1557	18.69	25.74	123.93	**0.93**
Warrington	12.5264	19.53	24.61	182.58	**0.92**
Bradford	18.8684	24.33	22.96	85.42	**0.92**
Tower Hamlets	19.7035	26.97	22.25	56.83	**0.89**
Rotherham	16.249	22.77	30.20	75.66	0.89
Redcar and Cleveland	15.0208	22.29	24.30	125.91	**0.82**
Hackney	21.4206	25.40	18.78	68.80	**0.81**
Waltham Forest	16.3565	24.84	26.56	73.39	**0.79**
County Durham	14.2547	22.78	29.16	91.88	**0.75**
Bedford	16.1662	20.69	26.61	103.95	**0.72**
Leicester	17.7246	23.48	23.76	80.09	**0.68**
Kirklees	17.0568	20.45	28.58	79.63	**0.67**
Southampton	17.3774	21.90	21.66	109.46	**0.66**
Bolton	16.1414	20.80	26.10	102.03	**0.66**
Coventry	15.8549	23.53	29.51	55.44	0.62
Thurrock	17.674	25.62	26.65	34.92	**0.59**
Derby	18.9108	22.96	18.43	91.22	**0.48**
Liverpool	15.4758	22.88	21.53	106.17	**0.47**
Swindon	17.3168	20.42	18.93	124.79	**0.46**
Enfield	14.9206	25.46	26.36	53.03	**0.41**
Northumberland	12.9693	20.73	23.80	128.37	**0.38**
Greenwich	16.896	25.12	18.98	80.75	**0.37**
Northamptonshire	15.8705	16.97	23.45	129.17	**0.34**
Plymouth	18.4369	18.58	21.00	103.72	**0.33**
Birmingham	13.7211	25.57	26.44	55.96	0.31
Newcastle upon Tyne	15.2019	24.57	21.96	72.61	**0.24**
Lincolnshire	16.3092	20.59	25.21	69.20	**0.19**
Cumbria	14.4676	20.22	22.07	112.05	**0.18**
Derbyshire	15.1177	18.72	21.79	119.23	**0.17**

Calderdale	17.057	20.78	21.89	79.88	**0.16**
Somerset	14.1927	18.30	23.34	120.98	**0.16**
Hounslow	12.6244	22.49	25.22	86.79	**0.13**
Sutton	12.7706	19.00	27.24	100.16	**0.11**
Medway	17.6233	20.55	23.22	60.75	**0.09**
Lancashire	14.7688	18.75	21.99	112.01	0.06
Sefton	12.4431	21.46	22.11	110.06	**0.03**
Bury	16.251	20.50	23.27	70.34	**0.03**
Redbridge	12.1484	24.99	25.72	58.52	**0.03**
Haringey	15.6097	24.79	20.94	55.31	**0.02**
Lewisham	15.4933	24.02	16.52	88.63	**-0.03**
Leeds	16.6914	19.93	20.56	83.28	**-0.04**
Central Bedfordshire	15.8403	16.50	22.40	108.76	**-0.04**
Portsmouth	15.1733	21.71	20.77	79.28	**-0.08**
Southend-on-Sea	17.9892	18.61	24.44	51.50	**-0.08**
Telford and Wrekin	16.4587	21.53	24.30	41.02	-0.11
Islington	20.0725	23.43	15.22	40.93	**-0.19**
Cheshire East	16.3966	16.55	17.50	123.02	**-0.19**
Westminster	14.1099	24.44	20.05	62.16	**-0.19**
Kent	16.3154	18.83	19.98	84.57	**-0.23**
Stockport	14.3127	17.62	21.51	103.48	**-0.26**
Cornwall	14.812	16.60	21.06	109.31	**-0.26**
Sheffield	16.9784	21.14	21.51	43.36	**-0.28**
Lambeth	14.6414	24.64	16.38	71.10	**-0.29**
Staffordshire	13.5054	19.88	23.48	73.80	**-0.33**
Milton Keynes	13.2572	20.95	19.58	92.77	-0.33
Hillingdon	11.6414	22.03	27.48	46.64	**-0.34**
Croydon	12.0044	23.65	22.92	58.39	**-0.36**
Barnet	17.2656	18.20	21.39	57.22	**-0.39**
North Yorkshire	15.6286	17.12	19.10	97.50	**-0.41**
Bournemouth	13.8462	17.33	17.39	125.08	**-0.42**
Hammersmith and Fulham	13.5847	21.50	22.54	57.16	**-0.43**
Bexley	11.6884	21.78	19.66	93.25	**-0.43**
Poole	13.7409	15.95	17.37	136.08	**-0.44**
Suffolk	13.8971	17.32	23.20	82.71	**-0.46**
Havering	13.4809	22.75	22.37	42.02	-0.51
Isle of Wight	14.0896	20.02	16.08	100.30	**-0.51**
Southwark	12.2347	24.48	16.82	76.49	**-0.52**
Herefordshire, County of	12.1972	18.73	23.22	80.90	**-0.55**

Norfolk	13.8459	18.23	21.79	76.82	**-0.55**
Kensington and Chelsea	13.1544	21.10	20.93	64.13	**-0.57**
Bristol, City of	11.1372	20.50	17.25	112.90	**-0.59**
East Sussex	14.1336	15.92	22.57	85.03	**-0.59**
Hampshire	14.3627	17.20	19.06	91.87	**-0.63**
Gloucestershire	14.3373	17.75	18.89	87.45	**-0.65**
Reading	13.5905	20.59	18.95	70.65	-0.65
Bromley	13.7574	14.97	21.80	95.42	**-0.68**
Ealing	11.0004	23.80	21.38	50.11	**-0.69**
Essex	13.8413	17.93	21.78	67.69	**-0.70**
Worcestershire	14.6702	18.55	21.06	57.56	**-0.71**
Solihull	10.47	16.29	25.72	89.72	**-0.71**
Wiltshire	14.0287	15.25	17.64	114.53	**-0.72**
Cheshire West and Chester	12.6692	18.31	19.72	87.78	**-0.73**
East Riding of Yorkshire	10.8122	15.47	27.42	75.79	**-0.78**
Leicestershire	12.0837	18.39	23.33	64.40	**-0.79**
Warwickshire	12.6379	17.29	21.61	78.24	-0.80
Camden	16.3587	21.69	16.71	33.06	**-0.82**
Merton	11.4958	21.73	19.64	56.91	**-0.90**
Cambridgeshire	14.5432	15.14	20.34	75.64	**-0.92**
Harrow	9.0369	19.99	27.78	34.43	**-1.01**
Trafford	12.7191	16.43	20.84	71.64	**-1.02**
Brighton and Hove	17.974	14.13	16.12	66.79	**-1.03**
West Sussex	12.8122	15.10	19.44	88.68	**-1.06**
Dorset	11.4927	16.09	18.64	94.61	**-1.11**
Shropshire	14.0359	15.95	19.74	61.37	**-1.12**
West Berkshire	13.0515	15.55	18.69	81.30	-1.13
Wandsworth	13.1966	18.79	16.64	63.89	**-1.15**
Bracknell Forest	13.2628	17.93	15.10	72.81	**-1.25**
Hertfordshire	12.6702	15.25	20.29	65.19	**-1.27**
Kingston upon Thames	15.452	15.52	19.35	36.76	**-1.31**
Devon	13.5075	14.48	16.87	80.94	**-1.33**
South Gloucestershire	10.4883	17.04	18.74	75.60	**-1.37**
North Somerset	11.0771	15.06	18.10	90.07	**-1.37**
Rutland	9.2572	15.68	20.43	NA	-1.41
Windsor and Maidenhead	11.1609	14.78	18.22	74.99	**-1.56**

York	9.0074	17.41	13.81	85.42	-1.80
Buckinghamshire	9.5544	15.19	18.29	64.77	**-1.84**
Oxfordshire	10.7041	16.15	15.75	59.79	**-1.86**
Surrey	10.9493	13.88	16.24	72.11	**-1.88**
Bath and North East Somerset	13.4158	12.89	11.17	71.53	**-2.09**
Wokingham	8.1314	13.93	15.37	63.50	**-2.41**
Richmond upon Thames	9.8136	11.37	12.97	61.33	**-2.68**

3. Access to Health Assets and Hazards Index

AHAH is a multi-dimensional index developed by the Consumer Data Research Centre for Great Britain measuring how 'healthy' neighbourhoods are. It combines together indicators under four different domains of accessibility:

- Retail environment (access to fast food outlets, pubs, off-licences, tobacconists, gambling outlets),
- Health services (access to GPs, hospitals, pharmacies, dentists, leisure services),
- Physical environment (Blue Space, Green Space - Active, Green Space - Passive), and
- Air quality (Nitrogen Dioxide, Particulate Matter 10, Sulphur Dioxide).

Place	AHAH Index
Kensington and Chelsea	100.000
Islington	100.000
Westminster	100.000
Tower Hamlets	99.208
Hammersmith and Fulham	95.196
Camden	93.483
Lambeth	91.985
Southwark	91.243
Hackney	90.862
Kingston upon Hull, City of	90.024
North East Lincolnshire	84.713
Haringey	82.508
Portsmouth	80.206
Newham	79.818
Wandsworth	79.583
Brent	69.440
Rutland	68.646
Waltham Forest	65.011
North Lincolnshire	63.083
Lewisham	63.040

Southampton	57.744
Sandwell	57.736
East Riding of Yorkshire	57.188
Ealing	53.112
Greenwich	46.661
Lincolnshire	44.797
Barking and Dagenham	44.612
Redbridge	42.103
Hounslow	41.084
Nottingham	39.884
Nottinghamshire	38.828
Southend-on-Sea	38.556
Brighton and Hove	38.194
Enfield	36.892
Merton	35.672
Salford	34.527
Suffolk	33.888
Thurrock	33.115
Bolton	32.653
Blackpool	31.938
Norfolk	31.766
Leicestershire	31.590
Walsall	29.404
Bexley	29.099
Croydon	28.872
Wolverhampton	28.010
Manchester	27.570
Slough	26.364
Liverpool	26.203
Birmingham	25.921
Sefton	23.511
Bristol, City of	20.982
Leicester	20.589
Barnet	20.139
Derbyshire	19.555
Wigan	19.031
North Yorkshire	18.897
Trafford	18.761
Sheffield	18.442
Richmond upon Thames	18.222
Hillingdon	17.860
Leeds	17.540

Derby	15.919
Cornwall	15.739
Bury	15.716
Harrow	15.112
Havering	14.652
Bournemouth	14.589
Oldham	14.458
Cambridgeshire	13.961
Herefordshire, County of	13.389
Hartlepool	13.007
Bradford	12.501
Kingston upon Thames	12.364
Hampshire	12.072
Dudley	11.909
Plymouth	11.724
Cheshire East	11.299
Halton	11.014
Shropshire	10.893
Warrington	10.701
Wakefield	10.552
Northamptonshire	10.247
Northumberland	9.662
Sutton	9.631
Stockport	9.445
Medway	9.260
Essex	9.154
Peterborough	8.964
Cumbria	8.793
Redcar and Cleveland	8.542
Rotherham	8.476
Kent	8.328
Middlesbrough	8.136
Rochdale	8.066
St. Helens	7.631
Tameside	7.547
Isle of Wight	7.469
Reading	7.197
Oxfordshire	7.123
Bedford	7.099
Cheshire West and Chester	6.767
Bromley	6.421
Knowsley	6.313

South Gloucestershire	5.882
Somerset	5.844
Swindon	5.737
Doncaster	5.701
Worcestershire	5.368
Central Bedfordshire	5.238
York	5.069
Coventry	5.059
Luton	4.872
Devon	4.843
Staffordshire	4.786
Warwickshire	4.773
North Tyneside	4.770
Bath and North East Somerset	3.938
Lancashire	3.880
Wirral	3.878
Windsor and Maidenhead	3.848
Sunderland	3.845
Wiltshire	3.799
East Sussex	3.746
Poole	3.619
West Sussex	3.522
Gloucestershire	3.380
Kirklees	3.369
Dorset	3.126
Blackburn with Darwen	2.829
North Somerset	2.536
Hertfordshire	2.463
Calderdale	1.808
Milton Keynes	1.763
Buckinghamshire	1.703
Solihull	1.427
Torbay	1.261
Newcastle upon Tyne	1.167
Darlington	1.067
Surrey	0.999
Telford and Wrekin	0.968
West Berkshire	0.908
Gateshead	0.845
Barnsley	0.720
County Durham	0.452
South Tyneside	0.000

Bracknell Forest	0.000
Stoke-on-Trent	0.000
Stockton-on-Tees	0.000
Wokingham	0.000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